EVALUATION

Cross-Border Health Integrated Partnership Project

Performance and Costing Evaluation

March 2020

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ABSTRACT

East Africa and Southern Africa are the two regions most affected by the HIV/AIDS epidemic worldwide. East Africa alone is home to more than six million people living with HIV/AIDS. People whose occupations require travel, such as truckers and fisherfolk, are a priority population with heightened risk for HIV. Many of the people who inhabit areas regularly visited by mobile populations are also part of this priority population.

The Cross-Border Health Integrated Partnership Project (CB-HIPP) worked from 2014–2019 to extend high-quality integrated health services to cross-border and mobile populations in strategic border areas and waterways in East Africa. As stakeholders consider a transition plan for CB-HIPP project activities, the United States Agency for International Development (USAID) East Africa Mission contracted with MEASURE Evaluation, which is funded by USAID and the United States President's Emergency Plan for AIDS Relief, to conduct a performance evaluation of CB-HIPP and to assess the cost of CB-HIPP programmatic scale-up. The performance evaluation gathered information about each component of the program's Standard Package of activities, and the cost assessment developed a model to project the price of various scale-up scenarios.

Results indicate that the CB-HIPP model worked well to extend services to cross-border and mobile populations. Stakeholders were satisfied with the program and expressed interest in extending the reach and scope of the activity. The estimated cost of scaling up the program to six to ten additional sites ranges from $1.3–2.6 million per year. Costs vary based on the number of sites and type of implementing partner selected. At a dissemination meeting in February 2020, stakeholders discussed recommendations regarding the following topics: several operational modifications to the program, programmatic expansion, support for the continued development of the interoperable digital HMIS and portable insurance scheme, and work with stakeholders to build consensus on who will lead policy advocacy moving forward.

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March 2020

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Cover

A ferry crossing Lake Victoria. Photo: Emily Weaver, MEASURE Evaluation

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ABBREVIATIONS

ART	antiretroviral therapy
C/DHMT	county/district health management team
CB-HIPP	Cross-Border Health Integrated Partnership Project
CBHU	cross-border health unit
CBPE	cross-border peer educator
DHIS2	District Health Information Software, version 2
EAC	East African Community
EMR	electronic medical record
FEAFFA	Federation of East African Freight Forwarders Associations
FP	family planning
FSW	female sex worker
HCW	healthcare worker
HMIS	health management information system
HTC	HIV testing and counseling
M&E	monitoring and evaluation
MOH	ministry of health
MSM	men who have sex with men
PE	peer educator
PEPFAR	United States President's Emergency Plan for AIDS Relief
SOP	standard of practice
STI	sexually transmitted infection
TB	tuberculosis
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

East Africa and Southern Africa are the two regions most affected by the HIV/AIDS epidemic worldwide. East Africa alone is home to more than six million people living with HIV/AIDS. Mobile populations, such as truckers and fisherfolk, compose a priority population with heightened risk for HIV. Populations that inhabit areas frequented by mobile populations also face increased risk (Bwayo, 1994; Delany-Moretlwe, Bello, Kinross, Oliff, Chersich, Kleinschmidt, & Rees, 2014; Kissling, et al., 2005; Mbugua, 1995; Opio, Muyonga, & Mulumba, 2013; and Ramjee & Gouws, 2002).

Meeting the needs of cross-border and mobile populations requires both collaboration among stakeholders from different countries and regional policy and programming approaches. The East Africa Cross-Border Integrated Health Study (MEASURE Evaluation, 2017) found that loss to follow-up plagued care and treatment programs at cross-border health facilities. Further, across all programs examined in the study—HIV, antenatal care, immunizations, prevention of mother-to-child transmission, and tuberculosis (TB) treatment—health facilities could not easily distinguish loss to follow-up from silent transfers to another health facility, particularly if the health facility was on the other side of an international border. Healthcare workers (HCWs) at the facilities included in the study reported that the main barrier to developing a system for cross-border collaboration and patient referral was the lack of a mechanism to support such a system, which they believed could improve both retention in care and continuity of care.

The Cross-Border Health Integrated Partnership Project (CB-HIPP) was implemented from 2014 to 2019 in Burundi, Kenya, Rwanda, Tanzania, and Uganda with the goal of extending high-quality integrated health services in strategic border areas and waterways in East Africa for cross-border and mobile populations. CB-HIPP adopted an implementation science approach and serves as a learning laboratory for testing and disseminating evidence-based models for cross-border health programming. Over the CB-HIPP project, a Standard Package of activities was developed as a model for this and other cross-border programming efforts. The Standard Package comprises seven key components:

1. A functional coordination and collaboration system
2. A functional direct service delivery and referral system
3. An interoperable digital health management information system (HMIS)
4. Portable healthcare financing options
5. Capacity strengthening on migration health
6. Learning and knowledge management
7. Policy and regulatory support

As stakeholders consider a transition plan for CB-HIPP project activities, the United States Agency for International Development (USAID) East Africa Mission enlisted MEASURE Evaluation, which is funded by USAID and the United States President's Emergency Plan for AIDS Relief (PEPFAR), to conduct a performance evaluation of CB-HIPP and assess the cost of CB-HIPP programmatic scale-up. The performance evaluation gathered information about each component of the CB-HIPP Standard Package from stakeholders at each cross-border site involved in the activity. The cost evaluation assessed the cost of CB-HIPP programmatic scale-up, including the development of a model to project various scale-up scenarios.

For each of the seven components of the Standard Package, the performance evaluation aimed to (1) determine what worked well and what did not work so well; (2) determine satisfaction of key stakeholders; and (3) examine contextual factors that facilitated or hindered the success of the component.

The performance evaluation conducted document review and semi-structured stakeholder interviews at each cross-border site and with local and national stakeholders. Over 100 interviews were conducted. Trends in performance monitoring data were also analyzed. The costing evaluation component used tools to collect retrospective cost data from the implementing partner and another local nonprofit organization to estimate the costs of implementing the CB-HIPP project by component in the Standard Package. A scale-up model was then constructed to estimate the project costs of expanding the number of project sites using an international or local implementing partner.

Results indicate that the CB-HIPP model worked well to extend services to cross-border and mobile populations. Stakeholders were satisfied with the program and expressed interest in extending the reach and scope of the activity. Key results are presented below by component of the Standard Package:

Coordination and collaboration system. CB-HIPP made a concerted effort to include stakeholders at all levels in decision-making processes from assessment through implementation and reported that this increased stakeholder satisfaction, buy-in, and ownership. National and site-level stakeholders expressed appreciation for the consultative process. At the site level, stakeholders were enthusiastic about cross-border coordination and collaboration.

Direct service delivery and referral system. Cross-border health units (CBHUs) have been shown to be a viable service delivery model to support 90-90-90 and other service delivery goals. They demonstrate local level commitment to cross-border health and the belief that healthcare should be accessible to all, and the success of these units demonstrates the ability and willingness of HCWs and managers to effectively coordinate and collaborate across borders. Although achievement of performance monitoring indicators was highly variable by site and country, two border sites in Uganda were most productive in terms of HIV and family planning (FP) performance indicators.

Capacity strengthening on migration health. Most of the capacity strengthening about cross-border and mobile populations had been provided in the early years of the CB-HIPP program, and although most stakeholders indicated it was important, few of them recalled the content of the training, suggesting that the requested refresher trainings may be needed. Stakeholders also strongly recommended that more (or even all) HCWs be trained to reduce stigma and improve service provision for cross-border and mobile populations.

Learning and knowledge management. On the ground, learning and knowledge management activities provide important information for CBHU programming and capacity strengthening for migration health. Stakeholders strongly recommended that the knowledge gained from the assessments and program activities be used to inform regional and national policies.

Policy and regulatory support. Stakeholders emphatically expressed the belief that national and regional policy is the key to sustaining the cross-border work initiated by CB-HIPP. There is widespread recognition that the Standard Package must be mainstreamed into national and regional policies if it is to be sustained, with awareness of varying levels of decentralization among countries. Stakeholders further recognize that coordination, collaboration, and policy engagement require a dedicated lead and funding to move the consultative process forward.

Interoperable digital HMIS. Although stakeholders recognize that an interoperable HMIS and a portable healthcare option are important components of the Standard Package, they acknowledge that it will likely take years for these components to be realized.

Portable heath care financing options. A lot of resources have been dedicated to studying the possible options for developing portable healthcare financing. However, stakeholders noted that "there is so much to do" before a portable healthcare option can become a reality.

The estimated cost of scaling up the program to six to ten additional sites ranges from $1.4–2.8 million per year. Costs vary based on the number of sites and type of implementing partner selected.

Recommendations were discussed during a dissemination workshop with stakeholders in February 2020. Workshop participants discussed the following options:

- Continue to investigate options and develop a cross-border HMIS and portable healthcare financing, disseminate CB-HIPP results, and budget for these activities (although they are not considered in the scale-up analysis).
- Continue to engage at all levels—regional, national, subnational, and site—to implement new sites and continue collaboration at existing sites.
- Identify a feasible solution to increase accessibility and facilitate problem-solving, such as locating an office in each country.
- Evaluate the need for local supervision or monitoring and evaluation (M&E) staff at more remote locations instead of relying on transportation from headquarters.
- Consider the menu of opportunities available for programmatic expansion and prioritize any additions to the existing scope.
- Identify the organization or actor that can serve a strong M&E role during development of the interoperable digital HMIS.
- Work with stakeholders to identify a willing party to serve as a regional champion at the East African Community (EAC) to take ownership of the development of portable healthcare financing options and move this component forward.
- Gain consensus on who will lead policy advocacy efforts to capitalize on the political will that has been developed and maintain momentum.

INTRODUCTION

Background

East Africa and Southern Africa are the two regions most affected by the HIV/AIDS epidemic worldwide. East Africa alone is home to more than six million people living with HIV/AIDS. People whose occupations require travel, such as truckers and fisherfolk, are a priority population with heightened risk of acquiring HIV. Many of the people who inhabit areas regularly visited by mobile groups are also part of this priority population. Fisherfolk in low- and middle-income countries worldwide constitute the highest risk group for HIV/AIDS (Kissling, et al., 2005). Recent data from studies around lakes in the region indicate higher HIV prevalence among fisherfolk compared to the general population, and among other groups generally considered at high risk of acquiring HIV (Opio, et al., 2013). Studies have also documented high rates of HIV among truck drivers in East, Central, and Southern Africa ranging from a low of 10 percent to a high of 56 percent (Ramjee & Gouws, 2002; Delany-Moretlwe, et al., 2014; Kissling, et al., 2005; Bwayo, 1994; Mbugua, 1995).

High-risk sexual behavior, including frequent unprotected sex with female sex workers (FSWs), alcohol abuse, gender-based violence, and anal intercourse with both women and men make these groups much more likely to acquire HIV (Morris & Ferguson, 2007). Paid sex contributes to the current HIV epidemic in East Africa—specifically in hot spot communities along major transport routes. An estimated 14 percent of new HIV infections in Kenya and 10 percent in Uganda are associated with sex work (Kenya National AIDS Control Council, 2009; Uganda AIDS Commission Secretariat, 2009). Women and vulnerable girls are another priority population particularly affected by HIV. In several East, Central, and Southern African countries, HIV prevalence among young women is up to five times higher than among men in the same age cohort.

Meeting the needs of cross-border and mobile populations in cross-border areas requires collaboration among stakeholders from different countries and regional policy and programming approaches. The East Africa Cross-Border Integrated Health Study (MEASURE Evaluation, 2017) found that loss to follow-up plagued care and treatment programs at cross-border health facilities. Further, across all programs examined in the study—HIV, antenatal care, immunizations, prevention of mother-to-child transmission, and TB treatment—health facilities could not easily distinguish loss to follow-up from silent transfers to another health facility, particularly if the health facility was on the other side of an international border. Healthcare workers at the facilities included in the study reported that the main barrier to developing a system for cross-border collaboration and patient referral was the lack of a mechanism to support such a system, which they believed could improve both retention in care and continuity of care.

Cross-Border Health Integrated Partnership Project

The CB-HIPP, led by FHI360 and supported by USAID, commenced operations on September 1, 2014, with the goal of extending quality integrated health services in strategic border areas and waterways in East Africa. CB-HIPP adopted an implementation science approach and serves as a learning laboratory for testing and disseminating evidence-based models for cross-border health programming. The CB-HIPP has three main objectives:

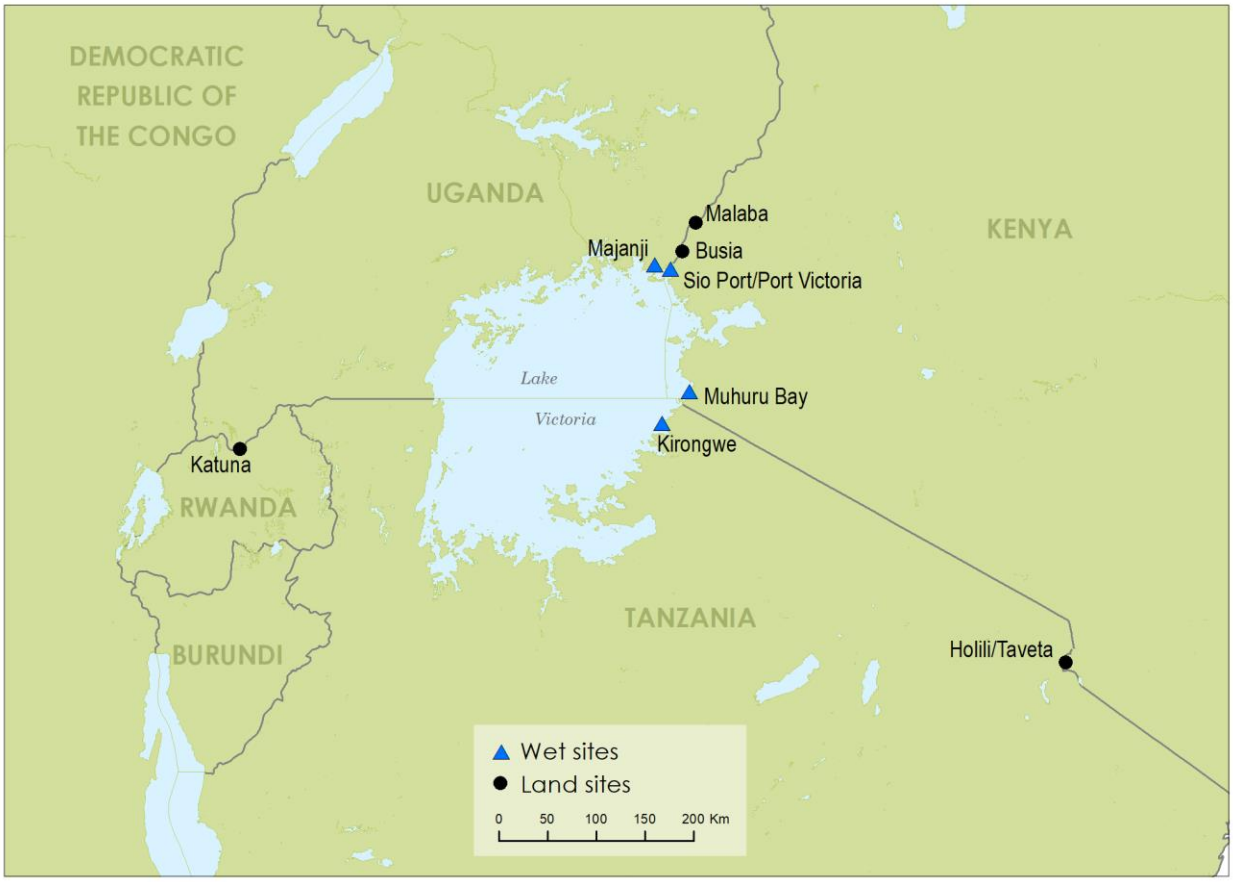
1. Increase access to and uptake of integrated health and HIV/AIDS services at strategic cross-border sites and select regionally recognized HIV transmission hot spots along East Africa transport corridors
2. Identify, implement, and test alternative health-financing models to strengthen the long-term sustainability of health and HIV/AIDS service delivery

3. Strengthen the leadership and governance of intergovernmental institutions so they can assist in improving the health of mobile and vulnerable populations

CB-HIPP is a learning project with mandate to define, implement, document, and disseminate lessons learned on sustainable models for cross-border health service delivery to meet the unique needs of cross-border and mobile populations living and traveling along major cross-border regions of East Africa. Cross-border and mobile populations comprise both key and priority populations. The following are the primary key populations affected by the HIV epidemic who live in cross-border areas: FSWs, men who have sex with men (MSM), and people who inject drugs. Priority populations are long-distance truck drivers, fisherfolk, cross-border traders, clearing and forwarding agents at border posts, vulnerable women and young girls, and other mobile groups.

Together with EAC regional stakeholders, six land and wet cross-border sites were selected for implementation (Figure 1). The project used a phased implementation approach for site-level activities given continuous partner state engagement and validation of sites after initial site selection.

Figure 1. CB-HIPP implementation sites



Over the life of the project, CB-HIPP developed and refined a Standard Package for Cross-Border Health Programming. The Standard Package has seven components:

1. A functional coordination and collaboration system
2. A functional direct service delivery and referral system

3. An interoperable digital HMIS
4. Portable healthcare financing options
5. Capacity strengthening on migration health
6. Learning and knowledge management
7. Policy and regulatory support

Implementation of CB-HIPP peaked in 2017 when the CBHU model was introduced and started to decline in 2018–2019 as the project prepared for closeout. The CBHU model developed by CH-HIPP is "an innovative model for cross-border health direct service delivery and referral across the HIV and other treatment cascades. The model is a platform that brings together health facilities, cross-border peer educators [CBPEs], and community health workers for cross-border health service delivery and referral" (USAID, 2019).

Regional stakeholders are currently conducting consultations to build consensus on the transition process for the Standard Package developed by CB-HIPP. Consultations will determine and clarify mandates and roles and responsibilities of key local, national, and regional stakeholders. As stakeholders consider a transition plan for CB-HIPP project activities, USAID/East Africa initiated a performance evaluation of CB-HIPP and assessment of the cost of CB-HIPP programmatic scale-up.

CB-HIPP Performance and Costing Evaluation

MEASURE Evaluation conducted a performance evaluation to gather information about each component of the Standard Package. Methods for the performance evaluation included review of CB-HIPP documents; qualitative key informant interviews and small group interviews with site (county/district), national, and regional stakeholders; and time-trend analysis of select CB-HIPP performance indicators.

Objectives of the Performance Evaluation

The performance evaluation had the following aims for each component of the Standard Package:

1. Determine what worked well and what did not work so well
2. Determine satisfaction of key stakeholders
3. Examine contextual factors that facilitated or hindered the success of the component

In addition, the evaluation team generated time trends for relevant CB-HIPP performance indicators for each of CB-HIPP's six implementation sites (Busia, Kenya/Uganda; Malaba, Kenya/Uganda; Sio Port/Port Victoria, Kenya and Majanji, Uganda; Muhuru Bay, Kenya and Kirongwe, Tanzania; Taveta, Kenya and Holili, Tanzania; and Katuna, Uganda). These time trends were integrated with stakeholders' views on whether and how CB-HPP contributed to changes in these indicators over time and whether and how CB-HIPP added value to national health interventions.

Objectives of the Costing Study

The costing study analyzed historic project expenditures on each of the seven program components and broke down these expenditures by category. The cost of CB-HIPP programmatic scale-up was then assessed and a model was developed to project the following scale-up scenarios: scale-up under an international implementing partner, a local organization, and an international implementing partner working with local service delivery partners.

METHODS

Performance Evaluation

Document Review

The MEASURE team reviewed many CB-HIPP project documents in preparation for the performance evaluation: annual progress reports (2015–2019), CB-HIPP's performance monitoring plan, meeting reports (EAC inception meeting, Partner State entry meetings and data validation meetings, and site-level entry meetings), and documents and PowerPoint presentations describing lessons learned and the components of the Standard Package. The goal of the document review was to develop a thorough understanding of CB-HIPP's implementation process and the Standard Package to inform the development of key informant interview guides for the performance evaluation. CB-HIPP also provided data on several performance indicators for each of CB-HIPP's six sites for the years 2015–2019.

Stakeholder Interviews

MEASURE Evaluation worked with CB-HIPP staff to identify stakeholders to interview about each Standard Package component and level (site, national, and regional). We hired a local consultant to schedule interviews and manage field logistics.

We developed interview guides to gather background information for each component of the Standard Package and collect stakeholders' perspectives on (1) what worked well, (2) programmatic (i.e., internal to CB-HIPP) challenges, (3) contextual factors that facilitated or hindered the success of each component, and (4) stakeholder recommendations for future programming. A general section of each guide prompted interviewers to ask how CB-HIPP contributed to improvement in various HIV, TB, and FP indicators of interest.

The guides were semi-structured and questions were selected for each stakeholder based on their involvement with CB-HIPP and the various components. A team of three MEASURE Evaluation staff conducted interviews in October 2019. Through numerous follow-up questions and probes, we sought to ensure that each question was fully answered, and extensive notes were taken during all interviews.

Over 100 stakeholders participated in interviews, including one regional stakeholder, eight national stakeholders in Kenya and Uganda, 83 site-level stakeholders across the six implementation sites, and 11 CB-HIPP and CB-HIPP implementing partner staff. In general, national level stakeholders mainly discussed coordination and collaboration, learning and knowledge management, interoperable HMIS, and policy. Site-level stakeholders at facilities mainly discussed service delivery and referrals as well as capacity building for migration health. Site-level stakeholders at the management level addressed service delivery and referrals, coordination and collaboration, interoperable HMIS, and policy. Portable healthcare options were addressed by two stakeholders. The full list respondents and their roles can be found in Appendix A.

Analysis

For each component of the Standard Package, a matrix was created to organize responses by topic area, noting level of respondent (site, national, regional) and location of respondent (site, country, regional).

The interview team identified relevant themes and patterns of responses for each component of the Standard Package. For four components (functional coordination and collaboration system, functional service delivery and referral system, capacity strengthening for migration health, and learning and knowledge management),

analysis focused on what worked well, programmatic challenges, contextual factors that hindered or facilitated implementation, stakeholder recommendations, and stakeholder satisfaction. For the remaining three components, which are works in progress (interoperable HMIS, portable healthcare options, and policy and regulatory support), analysis focused on identifying next steps, challenges, and stakeholder recommendations.

Time trends for the relevant CB-HIPP performance indicators were generated for each study site and integrated into the final report.

Costing Study

Data Collection

We developed tools to collect cost data from CB-HIPP to inform the costing analysis and scale-up model. These cost data included indirect costs, salaries/level of effort, and other direct costs. The tools were completed via in-person meetings and email follow-up with implementers. We used the data collection tools to obtain detailed information on the structure and function of CB-HIPP, including the breakdown of the seven standard package components. We extracted relevant information from written project documentation and records, supplemented by interviews. This information informed the mapping of costs to the seven components and helped us understand the cost of the various processes involved in CB-HIPP.

We collected retrospective cost data from multiple sources, including expenditure summaries, accounting/financial accounts, and budgets to calculate and analyze the costs of CB-HIPP. These data include both economic and financial costs of the various activities performed over the project timeline, recurrent costs of project implementation and delivery (staff and office costs and transportation), and capital costs of those items with a useful life that spans multiple periods (vehicles and equipment). We used an ingredients approach to understand the resources needed to implement project activities under scale-up scenarios.

We collected cost data from the central level and conducted interviews with staff to contextualize these cost data. The interview responses supported our analysis of expenditure data, helped us assign cost to categories, and informed the scale-up analysis. We conducted interviews with the chief of party, a finance officer, and an M&E officer. The evaluation team worked closely with these people to access costing data and reports, organize costing data, and allocate costs to project components.

First, we interviewed the finance and M&E officers to gain an understanding of the timeline, components, and cost structure of the project and the types of financial data available. We reviewed the project's annual and quarterly reports and detailed expenditure data for the period September 2014 to August 2019. The project did not track expenses by project components, and the components themselves were not finalized until 2017. The evaluation team worked with project staff to map project activities, and the resources used to execute these activities, to the seven project components.

We also collected sample budgets for activities such as meetings, workshops, and trainings. These budgets included activities at all levels of program operation, from trainings at the site level to national coordination meetings, monthly monitoring and technical support activities, and activities of service delivery partners. We also collected reports on cost-share commitments that represent economic costs not included in the expenditure reports.

Data Analysis

Cost Allocation

The project Finance Officer helped us analyze detailed expenditure data from the entire project period and break them down by the seven project components. We used a step-down costing approach to associate expenditures with the various intervention activities they funded. We assigned each activity to one of the categories of project input and associated these inputs with a project component. We used the following categories of input:

- Meetings, workshops, and training
- Personnel, including central office staff, U.S. based support, and consulting fees
- Transport and travel, including vehicle expenses, regional travel, and travel outside the region for conferences and HQ supervision
- Office expenses, including recurrent office expenses and office supplies
- Subawards to project partners (Though we did not collect complete data on these expenditures, we noted the major activities conducted under these awards.)

We allocated staff time to project components based on each person's job function. We allocated meeting, workshop, and training costs to project components based on the purpose of the event. Meeting costs that we could not allocate to a specific project component were assigned to the components based on percentages estimated by the finance officer. For each other category of expenses, the Finance Officer provided percentage estimates of the costs that should be allocated to each project component.

Scale-up

We constructed a scale-up model to estimate the cost of expanding the number of project sites, using an international or local implementing partner. Based on interviews with CB-HIPP staff, scale-up requires support at multiple levels—regional (EAC), national, and site and facility. The project provided recent budgets for engagements at each level, which we used to inform the scale-up scenarios. These budgets covered activities for each CBHU, including training and activities for CBPEs, quarterly engagement with local cross-border counterparts, and HCW training. The estimates of costs for these activities reflect the current structure for implementing the project components.

One element of the CB-HIPP program is monthly visits to each site for technical assistance and monitoring. These visits include refresher training as needed between CBHU training sessions. Training budgets were assumed to be the same for new and existing sites because trainings should be refreshed annually. Annual meetings between national counterparts are assumed to incur costs for each shared border for each country that shares the border. These consultation meetings are intended to occur annually; however, efforts to set up activities along new borders may require additional meetings, and the administrations at established borders have not historically met every year. In consultation with FHI 360, wet sites were assumed to require three times the transportation expenses of land border sites, owing to their remoteness and the need to engage water transportation services.

Central-level staffing requirements, rent, and vehicle costs were assumed to be unchanging in these scenarios, because the project previously supported a greater number of sites than it currently does. Staffing requirements used in the scale-up scenario reflect the current staffing mix. Note that in the future, it may be more efficient to reduce central-level transportation and increase staffing for supervision, M&E, etc. at the site-level. That analysis was beyond the scope of this study, and we retained the staffing mix at the time of the study. We

based our calculation of costs for scenarios that use a local implementing partner on regional staff salaries and office expenses from Northstar Alliance, a service delivery partner in CB-HIPP. We assumed overhead expenses for a local implementing partner to be 50 percent of those for an international implementing partner, and assumed that no international travel beyond the region would be required for the local implementing partner.

Data Synthesis

We synthesized data from the performance evaluation and costing study to generate recommendations for scale-up. We gathered stakeholder feedback at a regional dissemination meeting following the study, to inform recommendations.

Limitations

The strength of the performance evaluation lies in the comprehensive data collection from stakeholders at all sites involved in the CB-HIPP program. Few interviews were declined, although the views of stakeholders at the EAC are not represented, owing to a lack of staff availability and desire to participate. Not all national stakeholders were included by design, owing to resource limitations.

The availability of highly organized costing data from the implementing partner and participating NGO strengthen the evaluation and its results. However, these costing data were collected retrospectively, and the IP did not originally associate them with a component of the Standard Package of services. For the scale-up analysis, we only included four of the seven program components. Additional funds should be allocated in the future to analyze the other three program components. We used cost information from the subpartner, North Star Alliance, to approximate those of a local partner, but a regional partner may have provided a better estimate.

Additionally, we assume that the levels of service use at scale-up sites will be similar to an aggregate of levels at existing sites to begin the program scale-up, but larger sites will require additional resources to ensure that care is available to those who need it. More remote sites may require additional expenses for transportation or additional staff at the site to ensure that supervision, training, and M&E activities continue when travel to the site is difficult. We increased estimates of transportation costs for wet sites based on consultation with the CB-HIPP project. Because the current learning sites are dry sites, more detailed information about wet site transportation costs and options for staffing structure should be collected as the program expands.

RESULTS: TIME TRENDS FOR CB-HIPP PERFORMANCE INDICATORS

Results for select performance indicators are summarized below by site. Because the project was designed for learning, the results reflect lessons from implementation of the CBHU model rather than a large-scale service delivery implementation. Three of the sites had been fully engaged in CB-HIPP since its inception—(1) Malaba Uganda/Malaba, Kenya; (2) Busia Uganda/Busia, Kenya; and (3) Sio Port and Port Victoria, Kenya/Majanji, Uganda—and activities at these sites reflected this increased engagement. With the exception of the Malaba, Uganda/Malaba, Kenya site, the Kenyan border sites were relatively more productive than those on the Ugandan or Tanzanian side. However, HIV indicator tallies show the highest number of people reached with services in Uganda, largely because of CB-HIPP services at Malaba, Uganda and Katuna, Uganda. Performance indicators generally increased from FY2016 to FY2017 and decreased in FY2018 and FY2019 at the three initial border sites. This trend stems from the introduction of CBHUs as a learning model in 2017 and the resulting closeout process that began in 2018.

In the second phase of sites (specifically Muhuru Bay, Kenya/Kirongwe, Tanzania; Taveta, Kenya/Holili, Tanzania; and Katuna, Uganda/Gatuna, Rwanda), activities started in FY2018 and dropped off in 2019 as the project came to an end. The Malaba Uganda/Malaba, Kenya border site was by far the most productive, and this productivity was driven by services provision on the Ugandan side of the border. The Gatuna, Rwanda site had many difficulties engaging with CB-HIPP and was eventually dropped from the project. Therefore, it is not reflected in the tables.

Table 1 shows the number of people who received HIV Testing and Counseling (HTC) services and obtained test results. Over the course of CB-HIPP, 75,959 people received HTC services, of which 45.0 percent received services in Malaba, Uganda (34,203 people) and 28.7 percent received services in Katuna, Uganda (21,830 people).

Table 1. Number of people who received HIV testing and counselling services and received their test results, 2016–2019

		FY2016	FY2017	FY2018	FY2019	Total
Phase 1 sites	Malaba, Kenya	2,044	2,148	398	0	4,590
	Malaba, Uganda	9,645	8,948	10,167	5,443	34,203
	Busia, Kenya	608	2,078	429	69	3,184
	Busia, Uganda	0	1,389	429	23	1,841
	Sio Port, Kenya	1,790	2,788	340	43	4,961
	Port Victoria, Kenya	886	1,363	300	49	2,598
	Manjanji, Uganda	0	0	408	11	419
Phase 2 sites	Muhuru Bay, Kenya	N/A	N/A	527	0	527
	Kirongwe, Tanzania	N/A	N/A	566	1	567
	Taveta Kenya	321	N/A	425	0	746
	Holili, Tanzania	N/A	N/A	410	0	410
	Katuna, Uganda	3,310	3,452	9,077	5,991	21,830
	Total	18,604	22,249	23,476	11,630	75,959

N/A = not applicable

A total of 61,144 standard HIV prevention interventions with priority populations were completed from FY 2016–2019 in the CB-HIPP sites (Table 2). One-third, or 33.1 percent, of these interventions were conducted in FY 2018 (20,226).

Table 2. Number of standardized HIV-prevention interventions for priority populations completed that included the specified minimum components during the reporting period, 2016–2019

		FY2016	FY2017	FY2018	FY2019	Total
Phase 1 sites	Malaba, Kenya	4,055	3,074	394	81	7,604
	Malaba, Uganda	3,532	2,053	7,669	3,684	16,938
	Busia, Kenya	4,477	4,370	613	120	9,580
	Busia, Uganda	0	0	405	23	428
	Sio Port, Kenya	829	2,091	614	121	3,655
	Port Victoria, Kenya	0	0	314	0	314
	Manjanji, Uganda	0	0	654	61	715
Phase 2 sites	Muhuru Bay, Kenya	N/A	214	1,130	0	1,344
	Kirongwe, Tanzania	N/A	N/A	1,122	0	1,122
	Taveta Kenya	107	705	551	0	1,363
	Holili, Tanzania	N/A	N/A	467	42	509
	Katuna, Uganda	3,912	3,544	6,293	3,823	17,572
	Total	16,912	16,051	20,226	7,955	61,144

N/A = not applicable

Table 3 shows the number of individual- and/or small-group-level HIV preventive interventions conducted with key populations from 2016–2019. A total of 28,763 interventions were conducted with this service during the CB-HIPP program.

Far fewer FP services were provided compared to HIV-related services and outreach (Tables 4 and 5). The total number of community health workers providing FP information and/or services from 2016–2019 was 2,645. The trend for community health workers providing FP information/services is little bit different than that for HIV services and counseling. Provision of these services started earlier in the project in some of the Phase 2 sites and later in some of the Phase 1 sites. The Malaba, Kenya/Malaba, Uganda site remained the most active (as measured by this indicator), followed by the Busia, Kenya/Busia, Uganda site.

The total number of counseling visits for FP/reproductive health was 6,619 from 2016–2019 (Table 5). Most of these visits occurred in Malaba, Uganda (52.5%). The number of counseling visits for these services was otherwise intermittent at CB-HIPP sites by year and was not reported in most other sites during FY2018 and FY2019.

Table 3. Number of individual and/or small-group level HIV preventive interventions conducted with key populations that are based on evidence and/or meet the minimum standards required, 2016–2019

		FY2016	FY2017	FY2018	FY2019	Total
Phase 1 sites	Malaba, Uganda	3,069	2,058	3,464	740	9,331
	Malaba, Kenya	3,598	929	251	42	4,820
	Busia, Uganda	0	0	188	10	198
	Busia, Kenya	2,993	1,037	115	68	4,213
	Sio Port, Kenya	87	76	1	0	164
	Port Victoria, Kenya	0	0	15	0	15
	Manjanji, Uganda	0	71	23	0	94
Phase 2 sites	Muhuru Bay, Kenya	N/A	N/A	30	30	60
	Kirongwe, Tanzania	N/A	N/A	14	0	14
	Taveta Kenya	20	411	53	0	484
	Holili, Tanzania	N/A	N/A	105	12	117
	Katuna, Uganda	2,484	2,222	2,396	2,181	9,283
	Total	12,251	6,804	6,655	3,053	28,763

N/A = not applicable

Table 4. Number of additional U.S. government-assisted community health workers providing family planning information and/or services during the year, 2016–2019

		FY2016	FY2017	FY2018	FY2019	Total
Phase 1 sites	Malaba, Kenya	291	151	98	0	540
	Malaba, Uganda	0	0	120	70	190
	Busia, Kenya	0	0	152	0	152
	Busia, Uganda	257	0	70	0	327
	Sio Port, Kenya	31	60	91	0	182
	Port Victoria, Kenya	55	95	53	0	203
	Manjanji, Uganda	NR	NR	NR	NR	NR
Phase 2 sites	Muhuru Bay, Kenya	N/A	334	57	0	391
	Kirongwe/Tanzania	N/A	30	0	0	30
	Taveta, Kenya	77	N/A	46	0	123
	Holili, Tanzania	N/A	N/A	28	0	28
	Katuna, Uganda	88	186	110	25	409
	Total	799	926	825	95	2,645

NR = not reported; N/A = not applicable

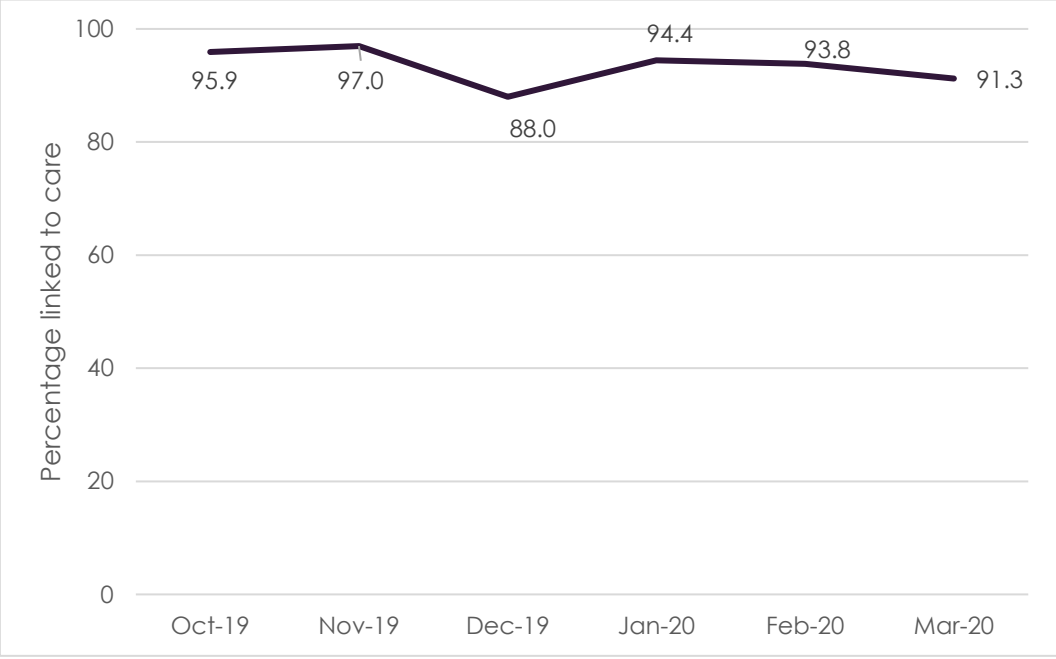
Table 5. Number of counseling visits for family planning/reproductive health as a result of U.S. government assistance, 2016–2019

		FY2016	FY2017	FY2018	FY2019	Total
Phase 1 sites	Malaba, Kenya	0	397	NR	NR	397
	Malaba, Uganda	518	1643	813	500	3,474
	Busia, Kenya	83	0	NR	NR	83
	Busia, Uganda	0	226	NR	NR	226
	Sio Port, Kenya	0	693	NR	NR	693
	Port Victoria, Kenya	NR	NR	NR	NR	NR
	Majanji, Uganda	0	79	NR	NR	79
Phase 2 sites	Muhuru Bay, Kenya	N/A	N/A	NR	NR	NR
	Kirongwe/Tanzania	N/A	N/A	NR	NR	NR
	Taveta, Kenya	516	N/A	NR	NR	516
	Holili, Tanzania	N/A	N/A	NR	NR	NR
	Katuna, Uganda	262	N/A	0	364	626
	Total	1,379	3038	1,338	864	6,619

NR = not reported; N/A = not applicable

More recent data show a high percentage of HIV-positive cross-border and mobile populations have been linked to care by the CB-HIPP program. An average of 93.4 percent of HIV-positive cross-border and mobile population members were linked to care in the six months between October 2019 and March 2020 (Figure 2).

Figure 2. Percentage of HIV-positive cross-border populations linked to care by CB-HIPP



RESULTS: PERFORMANCE EVALUATION

This section presents stakeholders' views on each component of the Standard Package for Cross-Border Health Programming.

Functional Coordination and Collaboration System

A key component of the Standard Package is coordination and collaboration at various levels (county/district [site], national, and regional). A regional project launch meeting introduced the project, followed by national entry meetings in Burundi, Kenya, Rwanda, Tanzania, and Uganda. At the site level, coordination and collaboration relied on existing structures such as county/district health management teams (C/DHMTs). At the site level, stakeholders (generally Ministry of Health [MOH] officials) facilitated cross-border consultations on a quarterly basis. A key role of coordination and collaboration systems was to identify priority cross-border health activities to address the needs of cross-border and mobile populations. The system also monitored implementation of cross-border activities.

What Worked Well and Achievements

National stakeholders reported that a main achievement of CB-HIPP was the project's ability to engage high-level regional and national stakeholders and bring them to the same table to create awareness of cross-border health issues.

At the site level, stakeholders reported that consultative meetings created linkages with colleagues from across the border and a platform for cross-border communication where previously there was none. Quarterly review meetings were reported to be helpful for keeping managers informed of progress and challenges. Stakeholders further noted that reaching consensus on priority activities was "easy."

Programmatic Challenges

Stakeholders who discussed coordination and collaboration did not report any programmatic challenges.

Contextual Factors

Contextual challenges were reported at the regional and national levels. Project stakeholders noted that the process of stakeholder engagement is a time-consuming, labor intensive process that requires a high degree of patience, tact, and diplomacy. Turnover in key government positions, especially at the national level, required that some coordination and collaboration discussions be started over. Stakeholders further noted that convening key regional and national bodies for consultative meetings was challenging at times, owing to the busy schedules of these personnel.

Many stakeholders noted different degrees of local authority by county, which variously facilitated and hindered coordination and collaboration. Kenya's devolved system allowed a high degree of authority at the county level, which facilitated coordination and collaboration. Uganda's decentralized system was also conducive to collaboration; although at times, the need for national-level approvals slowed progress. Tanzania's centralized system required various levels of approval. Stakeholders noted that the approval process could take time, but lines of authority were clear. In Rwanda, lines of authority and approval were not always clear. In addition, tensions between the national governments of Uganda and Rwanda hindered collaboration, and ultimately, Rwanda did not participate in the planned Gatuna/Katuna site.

Stakeholder Recommendations

Stakeholders at all levels recommended that coordination and collaboration systems involve not just health officials but immigration, security, and administration officials, too, given the project's cross-border context. Site-level stakeholders recommended increasing future opportunities for in-person cross-border meetings/forums for district/county officials, which were generally held quarterly during project implementation.

Stakeholders also recommended that CB-HIPP have a program office in each country for greater accessibility and to facilitate problem-solving.

Stakeholder Satisfaction

CB-HIPP tried hard to include stakeholders at all levels in decision-making processes, from assessment to implementation, and reported that this increased stakeholder satisfaction, buy-in, and ownership. National- and site-level stakeholders expressed appreciation for the consultative process. At the site level in particular, stakeholders were enthusiastic about cross-border coordination and collaboration. They reiterated that, previously, they had not known or even considered their counterparts across the border, but had subsequently developed productive relationships with them.

Functional Direct Service Delivery and Referral System

This component is operationalized largely by CBHUs. Six CBHUs were established (one at each implementation site) and were composed of two to six health facilities from each side of the border.[1] CBHUs were designed to strengthen cross-border community-facility linkages and support the 90-90-90 goals of the Joint United Nations Programme on HIV/AIDS.[2] CB-HIPP and site-level stakeholders described how CBHUs functioned. There was a high degree of consistency in their descriptions across the six sites.

CBHUs used volunteer CBPEs to identify cross-border and mobile populations, and CBPEs mobilized demand for services by referring peers to health facilities and informing them of moonlight outreaches supported by CB-HIPP at hot spots and beaches. Outreach services included HIV testing and service (HTS), initiation of antiretroviral therapy (ART) and linkage to care, TB screening, screening for sexually transmitted infections (STIs), cervical cancer screening, and FP services.

Cross-border peer educators played a key role in tracing HIV and TB defaulters and also provided health education, conducted TB screening, distributed condoms, and collected medications for peers.

Cross-border peer educators used various tools created by CB-HIPP to collect data and document their work. These included a CBPE *Client Screening Form* that screened for residency, nationality, mobility, and target population group, and a CBPE *Referral Form* that was used to refer clients to health facilities across borders. Other tools included a *CBPE Monthly Workplan Template* and CBPE *Educator Outreach Diary* used to document CBPE outreach activities.

[1] An exception is the Katuna, Uganda site where Rwanda (Gatuna) chose not to participate.

[2] By 2020, 90 percent of all people living with HIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained ART, and 90 percent of all people receiving ART will have viral suppression. Source: https://www.unaids.org/en/resources/909090.

Cross-border peer educators were supervised by an MOH community health supervisor (the position title varied by country) who reviewed data collected by CBPEs for completeness and accuracy. Cross-border peer educators, their supervisors, HCWs, and others had joint monthly cross-border meetings to review data.

Healthcare workers also used CB-HIPP tools. A *Facility Client Screening Form*, similar to the CBPE form, was used for walk-in clients. An *Inter-Facility Referral Form* was used to refer clients to other health facilities either within country or across the border, and a *Client Follow-Up Tool* was used to document efforts to make sure referred clients are linked to care. Healthcare workers used a *Cross-Border Health Services Directory* developed by CB-HIPP to aid inter-facility referrals. The Directory contained detailed contact information for all the facilities that belong to the CBHU.

A data manager entered data collected by CBPEs and HCWs using the tools described above into an Excel database created by CB-HIPP implementing partner Medic Mobile. Data were used by facility in-charges and C/DHMTs for decision making and planning, and these data were also sent to CB-HIPP.

What Worked Well and Achievements

Contribution to Selected Indicators

Stakeholders were asked about CBHUs' contributions to five key indicators:

- Identifying new cases of HIV
- Linking HIV-positive people to care
- Improving retention in care and treatment adherence
- Improving the TB treatment success rate
- Reducing discontinuation of FP

Stakeholders reported that identification of new cases of HIV increased as a result of CBPEs' mobilization of peers for moonlight outreaches where HTS was offered, and that their efforts to refer peers directly to health facilities for HTS also increased case identification. Several CBHUs were able to use CBPEs to implement index testing and partner notification services, which also aided with identification of new cases. At one CBHU, HCWs reported they would go to the hot spot of newly HIV-positive FSWs and sit with the FSW as she indicated which people were her clients (with the knowledge and consent of the clients).

Outreaches that immediately initiated ART when a person tested positive for HIV successfully linked many clients to care, as did those that referred HIV-positive clients to a CBHU facility of the client's choice.

Stakeholders expressed conviction that CBPE defaulter tracing increased retention in HIV care and that health education talks by CBPEs likely contributed to improved adherence to HIV treatment—and therefore to increased numbers of people living with HIV who were virally suppressed. Healthcare workers were also credited with improving retention in care through their efforts to ensure completion of referrals and through their efforts to trace defaulters through their contacts with HCWs at other facilities in the CBHU. At one CBHU, stakeholders reported that they visited facilities across the border on ART clinic days to see if their clients who had been lost to follow-up were receiving services on the other side.

Stakeholders reported that CBPEs also traced TB defaulters and thus could be contributing to the TB treatment success rate, though they noted that TB cases, and hence defaulters, were few compared to HIV defaulters.

With regard to FP, stakeholders noted that FP services were provided at moonlight outreaches and that facilities promoted long-term methods, but most were unsure if CBHUs played a role in reducing discontinuation of FP.

Other Achievements

Site-level stakeholders reported that inter-facility referrals were greatly improved under CBHUs. Because HCWs had formed relationships with their counterparts across the border and had a platform for communication (i.e., the CBHU), they could refer clients and follow-up to ensure that referrals were completed. Healthcare workers found the Cross-Border Health Services Directory extremely useful for referrals. One stakeholder noted that he used the directory to contact other facilities in the CBHU when his facility experienced a stock out of a particular drug. Using the directory, he could call contacts at other facilities to be sure they had the drug in stock before making the referral.

Most site-level stakeholders expressed appreciation for the tools that CB-HIPP developed for CBPEs and HCWs, because these tools helped them document the number of nonnational clients for budgeting and planning (mostly related to drugs and commodities). The tools also aided with quantifying cross-border and mobile population members attending services.

Prior to CB-HIPP, some clients would present falsely in each country as a citizen and initiate treatment as a new client, rather than stating their real citizenship and trying to continue their current treatment regimen. Some stakeholders reported that, under CB-HIPP, nonnational clients were more comfortable acknowledging their nonnational status when seeking care and thus were able to share their HIV status and request medication under their current regimen. These stakeholders reported that this resulted in less retesting (wasting of test kits) and double counting of HIV cases.

Monthly cross-border meetings of CBPEs and CBHU staff were greatly appreciated by site-level stakeholders. In addition to reviewing data collected by CBPEs, the meetings provided an opportunity to discuss challenges (e.g., issues completing forms, issues tracing defaulters) and potential solutions. Meetings were also used to update CBPEs, for example, when a new service was offered, such as pre-exposure prophylaxis.

Finally, stakeholders reported that the CBHU strategy of using CBPEs to mobilize demand, conducting moonlight outreaches to cross-border and mobile populations, and holding monthly meetings, etc., was a cost-effective way to improve on 90-90-90 goals and other service indicators.

Programmatic Challenges

Site-level stakeholders noted that turnover of CBPEs was a problem, owing to low "facilitation" payments for airtime and transport. Delays in payments to CBPEs, sometimes up to two months, was reported to be demotivating to CBPEs.

A few stakeholders reported that some CBPEs were not keeping their peers' HIV status confidential and had lost the trust of their peers.

Site-level stakeholders also reported that not all HCWs used the paper-based tools (e.g., Client Screening Form) because the HCWs were already overburdened with reporting. The paper-based tools and Excel database developed by CB-HIPP also resulted in extra data entry for facility data clerks. In some cases, site-level stakeholders reported that data entry was neglected.

Contextual Factors

Some clients still use different names on each side of the border, or give false names and contacts, and stakeholders reported that this practice continued to be a challenge for defaulter tracing. In addition, communication across borders was reported to be very costly as different cell networks are used in each country, and this posed a challenge for defaulter tracing.

Although TB and HIV treatment regimens are harmonized across Kenya and Uganda, they are different in Tanzania. The harmonized regimens made HCWs in Uganda and Kenya more comfortable referring across the border but resulted in hesitation for some at Kenya/Tanzania sites.

Stakeholders also reported that police/soldiers arrested fisherfolk for illegal fishing of undersized fish, which interrupted care for HIV-positive fisherfolk who were detained and missed appointments or otherwise lacked access to ART. Stakeholders further reported that CBPEs are sometimes harassed by police who wonder what their work is.

Finally, stakeholders reported some difficulty with border crossings at Kenya/Tanzania sites (high scrutiny from Tanzanian immigration officials) and even greater difficulty at the Katuna site because Rwanda periodically closed its border at Gatuna.

Stakeholder Recommendations

Stakeholders had several recommendations for improving the function of CBHUs:

- Increase community sensitization efforts by CBPEs to convince people that it is okay to access services on either side of the border so that people stop concealing their nationality and provide their true name and contact information.
- Increase the number of CBPEs (e.g., two per beach and one per hot spot), increase the CBPE facilitation amount, and ensure facilitation payments are made on time to prevent demotivating PEs.
- Provide CBPEs with identification cards or badges to show they are doing project work—both to identify themselves to peers and also to police who may question their activities.
- Make it a criteria for CBPE selection that CBPEs are people living with or affected by HIV (are a caretaker of someone with HIV) so that they are more respectful of keeping peers' HIV status confidential and can better relate to the experience of HIV-positive peers.
- Increase the number of moonlight outreaches, which were very effective at identifying new cases of HIV (high HIV-positive yield) and reaching cross-border and mobile populations for services.
- Expand the number of facilities in each CBHU. Instead of those just around the border, some stakeholders felt that the CBHU network should include the entire county/district on each side, because many people attend health facilities farther away from the border.
- Ensure that the client screening form is used by HCWs at all clinics that are entry points for care (e.g., labs and outpatient departments) for more accurate counting of nonnational people.
- Develop an HMIS that is interoperable across borders to facilitate referrals and defaulter tracing.
- Bring together key CBHU staff from different implementation sites to share best practices.
- Provide lubricants to FSWs and MSM, because government facilities do not provide them. (Lubricants reduce the risk of condoms breaking or slipping during intercourse, and this can make condom distribution programs more effective.)

- Expand cross-border work to health areas beyond HIV and TB. In particular, defaulter tracing is needed for immunizations.
- Sensitize police and soldiers on the importance of letting detained people living with HIV access ART. In addition, sensitize police, religious leaders, and other community stakeholders on cross-border and mobile populations to reduce stigma.

Stakeholder Satisfaction

Stakeholders at Kenya/Uganda sites were the most satisfied with CBHUs. CBHUs at these sites have been supported the longest and are receiving continuing support. The national systems of Kenya and Uganda (devolved and decentralized, respectively) are most conducive to collaboration, and stakeholders at Kenya/Uganda sites were most enthusiastic about what worked well and named numerous project achievements.

Project support has ended for Katuna and at Kenya/Tanzania sites, and implementation lasted just under a year at these locations. Although these stakeholders saw value in project activities, they have discontinued nearly all cross-border activities in the absence of CB-HIPP and financial support.

Interoperable Digital Health Management Information System

The paper-based tools and Excel database used by CBHUs are not interoperable across countries or with District Health Information Software, version 2 (DHIS2). As part of the Standard Package, CB-HIPP calls for the development of an interoperable digital HMIS to facilitate inter-facility referrals, defaulter tracing, and the continuum of care across borders for cross-border and mobile populations. The system would include locally validated digital protocols and algorithms for HIV and TB management using World Health Organization-approved standards across EAC partner states and would link with the EAC DHIS2 dashboard. The system would include both individual patient and facility level data.

Next Steps

Regional, national, and site-level stakeholders directly involved with HMIS work were asked about next steps to create an interoperable HMIS.

Stakeholders reported that there is much work to be done before the dream of a regional interoperable HMIS can be realized. At the regional and national levels, stakeholders must reach consensus on which indicators should be aligned/tracked. The national paper tools that support those indicators (e.g., TB and HIV registers and treatment cards) must be harmonized across countries, including the harmonization of medical terms and codes. Universal electronic medical records (EMRs) will need to be fully operational across countries. (Stakeholders reported that EMRs are currently in use only at high-volume facilities and, because use of EMRs is donor supported, these high-volume facilities are using different platforms.) Polices must be reviewed or developed to allow sharing of facility and individual patient data. Finally, HCWs must be trained on the system when developed.

Challenges

Stakeholders noted that, although the "technology is there" to create an interoperable HMIS, achieving consensus at the national and regional levels and navigating the legal and policy environment, especially around sharing of individual patient data, will be a long and challenging process. In addition, there are infrastructure challenges, such as limited Internet connectivity.

Stakeholder Recommendations

One stakeholder expressed that CB-HIPP or a similar project should provide a strong M&E role during the development and piloting of an interoperable HMIS to ensure implementation is as intended. This stakeholder also suggested that, for national buy-in, countries should play a role in management of the system as it is developed and piloted.

Portable Heath Care Financing Options

As part of the Standard Package, CB-HIPP also calls for the development of portable health insurance options to cover mobile population members when they are outside of their home country. Under CB-HIPP, the implementing partner Abt Associates conducted several studies to inform the development of portable health insurance options. This partner examined the cost of a defined package of health services (HIV, TB, FP, etc.) in Kenya, Rwanda, Tanzania, and Uganda to compare costs and understand drivers of cost. Abt Associates also examined facility service readiness at cross-border sites to provide the package of services. Abt Associates found healthcare costs were highest in Kenya and lowest in Uganda with Rwanda and Tanzania in the middle. Main cost drivers were identified as human resources and drugs and commodities. Findings also indicate that facility readiness to provide the package of health services examined was low, with most cross-border facilities unable to provide all services.

Abt Associates also examined demand for services and ability and willingness to pay for services among a subset of mobile populations (long-distance truck drivers, fisherfolk, clearing agents, and all households). Findings indicate that fisherfolk, who have the highest need for services, had the lowest ability and willingness to pay.

Finally, Abt Associates conducted an actuarial analysis, using Kenya as an example,. and determined that the least expensive option would be to cover everyone for services in East Africa outside of Kenya, not just mobile populations.

Next Steps

Stakeholders report that the next step in the process is to develop a road map for how to move forward with developing a portable healthcare option. They cautioned that more studies are not needed and warned against "analysis paralysis."

Challenges

Stakeholders noted that "there is so much to do" before a portable healthcare option can become a reality. For example, an interoperable HMIS, EMRs, and universal health coverage in all participating countries are necessary precursors to a public, portable healthcare option.

Recommendations

One stakeholder suggested that a regional champion at EAC needs to be identified to take ownership of the effort and move it forward, first by working with national stakeholders to create a road map for the development of a portable healthcare option. The stakeholder recommended piloting a portable option on a small scale and looking at the European Health Card to see if there are any lessons that can be applied, noting that "nothing like this exists in the African context."

Capacity Strengthening on Migration Health

As part of the Standard Package, CB-HIPP calls for the development of a regional toolkit for regular capacity strengthening of HCWs and managers working in cross-border settings. At the time of survey, CB-HIPP had adapted and implemented a CBPE training curriculum, and adapted a regional migration health curriculum (through the International Organization for Migration) for frontline HCWs and managers. Through CB-HIPP implementing partner Federation of East African Freight Forwarders Associations (FEAFFA), an HIV workplace module for freight forwarders was also developed.

CB-HIPP also facilitated the integration of mobility and cross-border and mobile-population-service-provision topics into continuous medical education sessions; the use of digital platforms such as WhatsApp for information sharing; and cross-border exchanges at CBHUs to share information about each county's standards of practice, treatment guidelines, etc., to promote mutual understanding of country systems.

What Worked Well and Achievements

Many stakeholders interviewed about capacity strengthening cited the cross-border exchanges, where they learned about health systems on other side of the border, as the most useful training received.

In Kenya and Uganda, trained HCWs reported they had joint trainings using a Kenyan national curriculum (*National Training Curriculum for Most at Risk Populations*) and that the training was "good."[3]

Some stakeholders reported that HCWs used to have a negative view of particular key population groups (i.e., FSWs, MSM, and people who inject drugs), but the training helped them understand that it was important to serve these populations without stigma, to reduce new infections.

CBPEs who received training reported that it was useful and that they learned about behavior change communication and were trained on health messages to share with peers. CBPEs also learned how the CBHU would function, their role, and how to complete data-collection forms.

The FEAFFA HIV workplace module has been incorporated into the East Africa Customs and Freight Forwarding Practicing Certificate as a mandatory component.

Challenges

Most stakeholders interviewed about capacity strengthening for migration felt that too few HCWs were trained (usually just two to three per health facility) and that, as a result, many HCWs still stigmatize key population members and are not sensitized on addressing key populations in the cross-border context.

Contextual Factors

Stakeholders noted that some trained HCWs have been transferred.

Stakeholder Recommendations

Stakeholders strongly recommended that more (or even all) HCWs be trained, and that refresher trainings should be provided because most HCWs were trained over two years ago.

[3] At Kenya/Tanzania sites, HCWs were trained separately. In Tanzania, HCWs were trained using a Tanzanian national curriculum (Participants Manual for Comprehensive Package of HIV and Health Interventions for Key Populations in Mainland Tanzania).

Some stakeholders advocated inclusion of a module in the HCW training curriculum on providing care to people who have experienced gender-based violence. Others noted that many cross-border and mobile population members are young and suggested that the training include a module on providing youth-friendly health services.

Refresher trainings for CBPEs were also strongly recommended because most were trained over three years ago.

Stakeholders also recommended that both HCW and CBPE training be followed by joint (cross-border) supportive supervision from C/DHMTs to ensure HCWs and CBPEs are interacting with cross-border and mobile populations appropriately and to improve on reporting and data management.

Stakeholder Satisfaction

Healthcare workers and CBPEs who were trained reported that the training was "good" but, in most cases, had trouble articulating specifics about what they learned or liked about the HCW and CBPE trainings. This may be because the trainings occurred two to three years ago. Stakeholders were most enthusiastic about cross-border exchanges and the opportunity these provided to understand health systems on the other side of the border.

Learning and Knowledge Management

As a learning project, CB-HIPP aimed to create knowledge to strengthen the evidence base for cross-border health and facilitate sharing of knowledge and use of evidence. The goal of which was to inform design and implementation of programs and policies on cross-border health programming. Areas of focus for CB-HIPP assessments and studies included mobility and its impact on access to health services; availability, demand, and access to cross-border health services; health-seeking behavior of cross-border and mobile populations in East Africa; the policy environment for cross-border health; and healthcare financing.

What Worked Well and Achievements

Several stakeholders reported that the studies conducted by CB-HIPP and the data gathered by CBHUs "opened our eyes to our own situation."[4] Information gathered and shared by CB-HIPP created awareness about cross-border and mobile populations, including the size of population groups at cross-border sites and why they chose to receive services on other side of the border. An example frequently reported by stakeholders was that FSWs avoided clinics where they might run into clients, so they sought services on the other side of the border. Other stakeholders explained that some cross-border and mobile populations attended facilities across the border because the facilities were actually closer than those in a home county or district, or because clients perceived the facility to offer higher quality services. Many chose to receive HIV services on the other side of border because of stigma.

The studies also identified unique needs of cross-border and mobile populations and the need for sensitization of HCWs. Some unique needs mentioned by stakeholders were that cross-border mobile groups were often pressed for time. For example, truck drivers have strict time requirements for delivery. Another commonly

[4] The term "eye opener" was used by several stakeholders to describe the awareness created by the data generated by CB-HIPP.

articulated example was that FSWs and fisherfolk are more active at night, and therefore, it is important to offer moonlight outreaches at accessible locations (e.g., hot spots, beaches).

At the site level, stakeholders reported the data were very useful for programming—"[we are] able to understand the number of FSWs, hot spots, challenges of being on ART as a mobile persons." Data on numbers of nonnational clients was also used for budgeting for drugs and commodities. One national stakeholder commented that the project had "a unique character that programming was based on data."

The assessments may have been used to inform policy. One national-level stakeholder in Kenya reported that the formative assessment was used to inform the National AIDS Strategic Framework.

Challenges

A few stakeholders suggested that, although dissemination efforts were good, they would have liked to have seen study findings disseminated even further and in abbreviated formats, and noted that the information could be useful beyond East Africa.

Contextual Factors

Stakeholders reported that it was time-consuming to go through ethics review committees in multiple countries and that this slowed progress.

Stakeholder Recommendations

Stakeholders strongly recommended that the knowledge gained from the assessments and program activities be used to inform regional and national policies.

Stakeholder Satisfaction

At the site level, stakeholders were highly appreciative of the assessments and data gathered for/at their site, because they were able to use the data directly for budgeting and planning.

In general, stakeholders praised the thoroughness of the assessments and the new knowledge that was uncovered about cross-border health issues.

Policy and Regulatory Support

Each of the components of the Standard Package has policy implications, requiring stakeholder engagement at the county/district, national, and regional levels to develop supportive policies. The Standard Package, which is drawn from the EAC minimum package of services for transport workers and mobile population, calls for the development of a regional service delivery framework that facilitates access to quality care for cross-border and mobile populations.

Next Steps

Numerous stakeholders tied sustainability of CB-HIPP's cross-border health work to policy. At all levels, they stressed the "need to entrench the work in policy to sustain it," noting that "continued national [and regional] engagement is a must." Stakeholders suggested that policy work should focus on mainstreaming cross-border health into national/regional systems. They also suggested "harmonization" across countries encompassing many areas, such as testing and treatment regimens (for HIV, TB, etc.), referral systems, data collection tools,

HCW training, and quality of service. Stakeholders also expressed that policy work should focus on data sharing and other policies necessary to support an interoperable HMIS.

Challenges

Many stakeholders asserted that policy change is an iterative process and "a long walk" that is complicated by different systems and processes in each country. As one stakeholder commented, "one year is a like a day in politics."

In addition, although stakeholders generally believed that the EAC has the role and authority to move the policy agenda forward, some noted that internal issues at EAC regarding where to house cross-border work (HIV/AIDS Unit or East African Health Research Commission) may present a roadblock to progress.

Stakeholder Recommendations

Stakeholders agreed that policy is needed for sustainability, but there were differences of opinion on who should take the policy process forward. Some think this is a role that can be transitioned to national governments and the EAC. Others think that CB-HIPP should lead policy efforts for cross-border health because they have data, lessons learned have "shown it can be done," and CB-HIPP has the ability and resources to engage and convene high-level stakeholders.

Regardless of who moves the policy agenda forward, stakeholders suggested that it was important to capitalize on the political will that has developed at the county/district level and not lose momentum. Some expressed concern that without CB-HIPP and a supportive regional policy framework, the work would "die."

Some stakeholders suggested creating policy briefs to disseminate findings widely to policy makers and others, noting that different products are needed for different audiences. One stakeholder recommended that CB-HIPP place a technical person at EAC to oversee and coordinate cross-border efforts to give focus to the EAC to prioritize the Standard Package agenda.

RESULTS: COSTING STUDY

The costing study analyzed historic project expenditures to explore spending on each of the seven program components and the breakdown of these expenditures by category. We then assessed the cost of CB-HIPP programmatic scale-up, including the development of a model to project various scale-up scenarios. The scenarios compared scale-up under an international implementing partner, a local organization, and an international implementing partner working with local service delivery partners.

Table 6 summarizes the total estimated expenditures on each of the seven program components over the reporting period September 2014 to August 2019, along with the percentage breakdown of costs to program components. The largest share of costs was spent on capacity strengthening on migration health (20%), followed by direct service delivery and referral (18%) and portable healthcare (18%).

Table 6: Cost breakdown by program components

Program component	Collaboration and coordination system	Portable health care	Direct service delivery and referral	Interoperable HMIS	Capacity strengthening on migration health	Learning and knowledge management	Policy and regulatory support	Total
Total expenditure ($)	1,624,198	2,207,390	2,167,757	738,453	2,869,278	1,205,645	1,261,662	12,074,384
Percentage of total expenditure	13	18	18	6	20	14	10	100

CB-HIPP project costs evolved over time. The project's components were developed in its early years, and it implemented these components at up to six sites, although the number of sites was scaled back to focus on learning sites along the Kenya/Uganda border. Project operations during the assessment focused on executing the CB-HIPP package at three learning sites. Research on portable healthcare financing options and cross-border HMIS slowed as the regulatory environment hampered development of these components. The costs in Table 6 represent the total expenditure by project component over the project history.

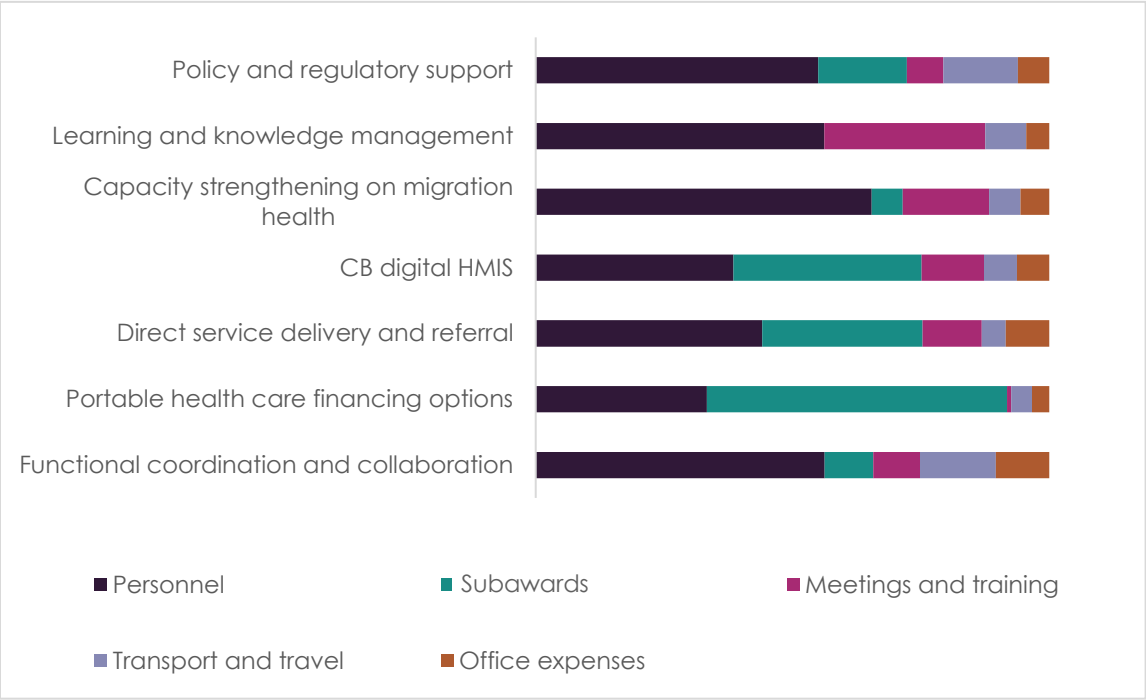
Figure 3 displays the expenditures for each project component by costing element. Personnel is the largest expenditure, representing 50 percent of the total. This includes cost for local staff at the project headquarters and above-site staff for project management. The second largest expenditure is subawards, which made up a significant fraction of costs for certain project components. The subawards for the development of portable healthcare financing options were used to conduct studies of the potential costs for these options in the region. Subawards were also used for the development of cross-border HMIS tools and continued to be used for direct service delivery. Subawards for direct service delivery were spent on personnel (approximately half), followed by meetings and training, with small amounts spent on office expenses and transport. Table 7 presents a mapping of key subawards for program components.

Table 7. Key subawards, subpartners, and activities conducted through subawards.

Key subawards	Partners	Activities
Functional coordination and collaboration	FEAFFA	Training curriculum for customs workers
Portable healthcare financing options	Abt Associates	Healthcare financing studies
Direct service delivery and referral	North Star Alliance Transcom	Link patients to health facilities
Cross-border digital HMIS	Medic Mobile	Develop digital health tools
Capacity strengthening on migration health and others	International Organization for Migration	Integrate migration health into public health training
Learning and knowledge management	N/A	N/A
Policy and regulatory support	African Institute for Development Policy	Policy briefs, studies, and dissemination

Meetings and trainings were the third largest source of expenditures, representing 13 percent of the total. These include such items as trainings for cross-border peer educators and HCW at the site level and coordination meetings at all levels. Expenditures on meetings and trainings represented 31 percent of expenditures categorized by the project component learning and knowledge management, which includes the site assessments. Transportation for headquarters staff performing training and supervision, and travel to local and regional meetings and international travel, represent a smaller portion of program costs, as do office expenses. As in Table 6, these breakdowns of costs represent historical expenditures over the lifetime of the project.

Figure 3. Cost breakdown by program component and category



CB: cross border

Scale-Up Scenarios

Ten cross-border sites were initially proposed for CB-HIPP activities—five land borders and five wet borders. These sites were located along the Kenya/Uganda, Rwanda/Uganda, Kenya/Tanzania, Rwanda/Tanzania, Burundi/Tanzania, Uganda/Tanzania, and Rwanda/DRC borders. Six of these sites were implemented (shown in Figure 1): three along the Kenya/Uganda border, two along the Kenya/Tanzania border, and one along the Uganda/Rwanda border. In 2019, the project shifted focus to the learning sites along the Kenya/Uganda border; these are the three sites in operation at the time of assessment.

We examined four scale-up scenarios that increase the number of sites from the initial three sites to the six implemented sites or the ten proposed sites. We also considered the cost of expanding the number of sites using an international or local implementing partner. The scale-up scenarios follow:

1. Expand to six implemented sites along three borders with an international implementing partner
2. Expand to six implemented sites along three borders with a local implementing partner
3. Expand to ten implemented sites along seven borders with an international implementing partner
4. Expand to ten implemented sites along seven borders with a local implementing partner

These scenarios contain elements of four project components. Functional coordination and collaboration, as well as policy and regulatory support, have been fostered through cross-border meetings that scale up with the number of borders. CB-HIPP supports direct service delivery through trainings and coordination meetings that scale up with the number of sites. Capacity strengthening on migration health is achieved through training of HCWs and CBPEs that scale up with sites.

The other three components—development of a cross-border HMIS, portable healthcare financing, and learning and knowledge management—are not explicitly accounted for in the scale-up scenarios. Development

of a cross-border HMIS has not been implemented because of policy barriers. Portable healthcare financing has been studied, but also has not yet been implemented. Learning and knowledge management activities, such as site assessments, have been conducted at each of the 10 sites featured in these scenarios. If additional or different sites were to be considered, the cost of site assessments under the current CB-HIPP structure would need to be considered. Each of these program components are important to the overall objectives of CB-HIPP, but some have been implemented to a lesser degree and lack evidence for scale-up.

Table 7. Annual cost of scale-up scenarios

Scale-up scenario	Annual cost (million USD)
1. Expand to previously implemented 6 sites using an international implementing partner	2.16
2. Expand to previously implemented 6 sites using a local implementing partner	1.41
3. Expand to 10 proposed sites using an international implementing partner	2.77
4. Expand to 10 proposed sites using a local implementing partner	1.96

Some of the resources required by the CB-HIPP program are fixed regardless of the number of sites in each scenario, such as central-level program staff (site-level staff increase) and office costs. Other resources vary by the number of sites, such as trainings, local and national cross-border meetings, and monitoring activities. The fixed expenses for program operations make up just over half of the total expenses in the baseline. Adding additional program sites increases total costs less than proportionally as a result. For more information about the assumptions used in the scenarios, refer to the Methods section.

Table 7 displays the annual estimated project cost under each scale-up scenario. It is assumed that these sites can be implemented at once, but interviews suggest that scale-up should be a stepwise process. The actual annual cost will depend on the number of sites that can be established and maintained in each year, according to the situation along each border. Establishing sites along one border of a country can help pave the way for national policies that support expansion along another border. However, each border brings unique challenges in coordination that must be overcome. On the other hand, these project sites have already begun the process of cross-border implementation, to some degree, and have regional relationships through the EAC to help support the process.

The figures in Table 7 provide information about the cost to continue the program at varying numbers of sites, assuming that these sites will require similar numbers of staff, CBPE, and similar levels of coordination as existing sites. The incremental cost of scaling up to 10 instead of six sites is similar whether a local or international implementing partner is used. The savings from using a local partner are mainly from reduced staffing costs.

In the longer term, the goal of CB-HIPP is to address the unique risk factors faced by mobile populations throughout the broader healthcare system. Many additional cross-border sites in the region experience the same issues with mobile populations as the ten sites previously assessed by CB-HIPP. CB-HIPP staff reported that the current program model was designed to scale up to new countries, borders, sites, and contexts. Clinicians should be trained on the specific risks to mobile populations and patients screened and documented appropriately using digital health tools. Domestic funding should be allocated for cross-border cooperation to improve patient loss to follow-up and commodity availability.

SUMMARY AND DISCUSSION

Overall, results of the performance evaluation show that the CB-HIPP program was highly valued by stakeholders and that there is a desire to continue the work of CB-HIPP. The components of the Standard Package are very interdependent and work together to create the success of the program; removing any of the key components of the package would have reverberating effects through the rest of the program. Two components—an interoperable HMIS and a portable health insurance package—have not yet been realized but are also believed to have high value in ensuring continuity of care for these populations.

Coordination and Collaboration System

CB-HIPP made a concerted effort to include stakeholders at all levels in decision-making processes, from assessment through implementation, and reported that this increased stakeholder satisfaction, buy-in, and ownership. National and site-level stakeholders expressed appreciation for the consultative process. At the site level, stakeholders were enthusiastic about cross-border coordination and collaboration. They reiterated that previously they did not know or even consider their counterparts across the border, but now had productive relationships with these counterparts.

A significant share of CB-HIPP resources were spent on coordination and collaboration systems, which are essential to cross-border health programming and underlie all other components of the Standard Package. This component is also closely tied to policy and regulatory support because regional policy engagement is an iterative consultative process that requires effective and sustained collaboration among Partner State stakeholders.

Direct Service Delivery and Referral System

CBHUs have been shown to be a viable service delivery model to support 90-90-90 and other service delivery goals. They demonstrate local-level commitment to cross-border health and the belief that healthcare should be accessible to all, as well as the ability and willingness of HCWs and managers to effectively coordinate and collaborate across borders.

Stakeholders at Kenya/Uganda sites were most enthusiastic about CBHU achievements. Their success can perhaps be attributed, to some degree, to national health systems (devolved and decentralized, respectively) that allow local-level authority and decision making, but also to the more sustained period of CB-HIPP support. Stakeholders at Kenya/Tanzania sites expressed appreciation for CB-HIPP's strategy and support, but project activities were not sustained at these sites following CB-HIPP's departure. This can perhaps be attributed, at least in some part, to the relatively short period of implementation at these sites.

Coordination and collaboration systems underpin the work of CBHUs, providing a necessary platform for planning and monitoring CBHU activities and providing outreach beyond the facility-level engagements. Stakeholders again suggested expanding program involvement to a more diverse set of stakeholders by sensitizing police and soldiers on the importance of the program's activities and specifically allowing detained people living with HIV to access ART. Additionally, providing for sensitization of police, religious leaders, and other community stakeholders on cross-border and mobile populations was a means that stakeholders suggested of reducing stigma for cross-border and mobile populations.

Although the CBHU model is viewed as successful by every stakeholder we spoke with, many suggestions for improvement focused on CBPEs who are a linchpin of this program. Stakeholders at CBHUs requested the

engagement of additional CBPEs to reach more cross-border and mobile populations and facilitating the CBPEs at a higher rate (and more timely manner) to sustain their motivation. Stakeholders also suggested that increased requirements for and sensitization of CBPEs, and provision of identification cards for CBPEs to be recognized by authorities, would result in more effective implementation of outreach activities.

Capacity Strengthening on Migration Health

Most of the training to strengthen the capacity of CB-HIPP partners to serve cross-border and mobile populations was provided in the early years of the CB-HIPP program. Although most stakeholders indicated it was important, few of them recalled the content of the training, suggesting that requested refresher trainings may be needed. Stakeholders also strongly recommended that more (or even all) HCWs be trained to reduce stigma and improve service provision for cross-border and mobile populations. Healthcare workers are frequently transferred in these areas, and thus, trainings for new HCWs arriving at CB-HIPP sites may also be necessary. Additionally, turnover among CBPEs may call for intermittent refresher trainings for new volunteers. Stakeholders suggested adding curriculum modules about gender-based violence and youth-friendly services, noting that training in these areas would be particularly relevant when working with cross-border and mobile populations.

Stakeholders reported that they valued the cross-border aspect of the CB-HIPP model, and many were enthusiastic about cross-border exchanges and the opportunity these provided to understand health systems on the other side of the border. Stakeholders also advocated for joint (cross-border) supportive supervision from C/DHMTs to ensure that HCWs and CBPEs are interacting with cross-border and mobile populations appropriately, and to improve on reporting and data management. Although these types of cross-border exchanges provide opportunities for improving service provision for targeted populations, they can also be complicated to plan and implement depending on the border site.

Learning and Knowledge Management

Stakeholders strongly recommended that the knowledge gained from the assessments and program activities be used to inform regional and national policies. On the ground, learning and knowledge management activities provide important information for CBHU programming and capacity strengthening for migration health. Several stakeholders commented on the uniqueness of CB-HIPP's focus on cross-border health work and the project's emphasis on using data to inform programming. Learning from assessments and programming also provides vital information for raising awareness about cross-border health issues for policy engagement. In general, stakeholders praised the thoroughness of the assessments and the new knowledge that was uncovered about cross-border health issues, particularly at the site level where stakeholders reported that they had gained the ability to use the data directly for budgeting and planning.

Some stakeholders suggested creating policy briefs to disseminate findings widely to policy makers and others, noting that different products are needed for different audiences.

Policy and Regulatory Support

Stakeholders feel adamantly that national and regional policy is essential to sustaining the cross-border work initiated by CB-HIPP. There is widespread recognition that the Standard Package must be mainstreamed into national and regional policies if it is to be sustained, and these efforts must account for varying levels of decentralization among countries. Stakeholders further recognize that coordination, collaboration, and policy engagement require a dedicated lead and funding to move the consultative process forward. However, there

were differing views about who is best suited to lead the process at this time. Some feel CB-HIPP or a similar donor-funded project, perhaps with a dedicated staff person at EAC, would be best placed to move the cross-border agenda forward. Others look to national governments and the EAC to fill this role.

Stakeholders acknowledged that policy work can be complicated by different systems and processes in each country. Stakeholders noted the importance of capitalizing on the momentum generated by the program at the county/district levels to move the policy agenda forward.

Interoperable Digital Health Management Information System

Although stakeholders recognize that an interoperable HMIS and a portable healthcare option are important components of the Standard Package, they acknowledge that it will likely take years for these components to be realized. One stakeholder suggested that CB-HIPP or a similar project should provide a strong M&E role during the development and piloting of an interoperable HMIS to ensure implementation is carried out as intended. This stakeholder also felt that, for national buy-in, countries should play a role in management of the system as it is being developed and piloted.

One of the biggest barriers to creating an interoperable HMIS will be achieving consensus at the national and regional levels and navigating the legal and policy environment. The policy framework for the sharing of individual patient data, in particular, will be a long and challenging process. Although the technology to create an interoperable HMIS exists, infrastructure challenges, such as limited Internet connectivity, will also need to be addressed.

Portable Heath Care Financing Options

A lot of resources have been dedicated to studying the possible options for developing portable healthcare financing options. However, stakeholders noted that "there is so much to do" before a portable healthcare option can become a reality. For example, an interoperable HMIS, EMR, and universal health coverage in all participating countries are necessary precursors before a public portable healthcare option can become a reality.

Costing Implications for Scale-Up of CB-HIPP

Four scale-up options were presented with estimates of associated cost for each scenario, varying from $1.3 to $2.6 million USD per year for between six and ten additional sites. Because the components of the Standard Package work in harmony to achieve success, it would be difficult to implement the components in a piecemeal fashion under a scale-up scenario. Learning and knowledge management activities for new sites outside of the 10 previously assessed would need to be considered separately from the costs estimated as they are important in feeding into the policy advocacy and regulatory support.

The majority of programmatic costs during CB-HIPP were related to personnel, highlighting the large percentage of staff time spent on the operation of the CB-HIPP model. Subawards were the second greatest share of the costs estimated across the components, although the share spent on subawards was highly variable for each component. Investments in meetings and training were also highly inconsistent across the seven project components and reflect the nature of work in each area. The largest share of meetings and training was spent on capacity strengthening on migration health and the smallest share of meetings and trainings was spent assessing portable healthcare financing options.

Although stakeholders were generally very satisfied with the work of CB-HIPP, they had two operational suggestions that would require additional resources to implement beyond what has been costed in this study:

1. Establish a project office in each country.
2. Increase the financial support provided to CBPEs and ensure payments are made on a timely basis.

Additional programmatic expansions suggested would also require additional resources that have not been estimated:

1. Extend coordination and collaboration systems to a greater range of stakeholders.
2. Possible assignment of a CB-HIPP staff-person at EAC to move the agenda forward.
3. Increase the number of face-to-face coordination and collaboration visits by CB-HIPP staff and continuing these throughout the project, and ensure that CBHUs and other stakeholders share knowledge, and lessons learned, across the border.
4. Increase the number of facilities involved in CBHUs beyond those closest to the border.
5. Increase the number of trainings, sensitization trainings, and joint learning activities for HCWs and others involved in CBHUs, and develop new modules on gender-based violence and youth-friendly services. (Our costing analysis includes two trainings per year for 30 HCWs per site, and the incremental training cost is under $300 for each HCW.)
6. Increase the number of moonlight outreaches.
7. Increase services offered, including the provision of lubricants to FSW and MSM and defaulter tracing for immunizations.
8. Increase the number of PEs. We estimate the incremental cost of adding a CBPE is less than $250 per year.
9. Increase trainings, sensitization and regular refresher trainings for PEs. Our costing analysis includes two trainings per year for 20 CBPE per site, with an incremental training cost of under $45 per PE.
10. Provide sensitization for other stakeholders, specifically police and soldiers.
11. Provide joint (cross-border) supportive supervision for HCWs and PEs.

Stakeholders involved in moving the CB-HIPP model forward should decide which of these suggestions are priorities.

RECOMMENDATIONS

Stakeholders were convened to discuss all components of the Standard Package and gave many thoughtful suggestions for the future of CB-HIPP. Summaries of their general recommendations, organized by topic and component, follow:

- Continue to investigate options and develop cross-border HMIS, establish portable healthcare financing, disseminate CB-HIPP results, and budget for these activities—which are not considered in the scale-up analysis.
- Continue to engage at all levels (regional, national, subnational, and site-level) to implement new sites and continue collaboration at existing sites.

Operational

Stakeholders suggested that having a program office in each country would increase accessibility and facilitate problem-solving. We recommend the following:

- Identify a feasible solution to increase accessibility and facilitate problem-solving.
- Evaluate the need for local supervision and M&E staff at more remote locations, instead of relying on transportation from headquarters.

Programmatic expansions

Stakeholders suggested numerous ways to expand the program. We recommend the following:

- Consider the menu of opportunities available and prioritize any additions to the existing scope.

Interoperable digital HMIS

A stakeholder suggested that CB-HIPP, or a similar project, provide a strong M&E role during development of the system. We recommend the following:

- Identify the organization or actor that can fulfill this role.

Portable healthcare financing options

A stakeholder suggested that a regional champion at EAC be identified to take ownership of the effort to move this component forward. We recommend the following:

- Work with stakeholders to identify a willing party to assume this role.

Policy and regulatory support

Stakeholders concurred that policy is needed for sustainability but had mixed opinions about who should move the policy process forward. We recommend the following:

- Gain consensus on who will lead policy advocacy efforts and capitalize on the political will that CB-HIPP developed.

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APPENDIX A. PERFORMANCE EVALUATION INTERVIEWEES

Table A1. Interviewees for the performance evaluation, listed by organization

Title	Organization
Regional stakeholders	
Information and communication technology principal officer	EAC
National stakeholders—Kenya	
Medical officer (TB/HIV)	National AIDS and STI Control Programme (NASCOP), MOH
Technical advisor to the director general	MOH, Kenya
Professor	School of Public Health, University of Nairobi
Director of biomedical informatics	IntelliSoft Consulting
Head of research	National AIDS Control Council
National stakeholders—Uganda	
National coordinator, HIV prevention	MOH, Uganda
Principal medical officer care and treatment	Department of Disease Control and Prevention, MOH, Uganda
Site stakeholders—Busia, Kenya; Busia, Uganda	
County director of health	MOH, Busia, Kenya
County AIDS and STI coordinator	MOH, Busia, Kenya
Public health educator (PHE)	MOH, Busia, Kenya
Subcounty AIDS and STI coordinator (SCASCO)	MOH, Matayos Subcounty, Busia, Kenya
Senior technical officer	AMPATH, Busia County, Kenya
PE Community health assistant (CHA)	Busia Subcounty Referral Hospital, Busia, Kenya
Public health officer Nurse counselor	Busia Subcounty Referral Hospital, Busia, Kenya AMPATH, Busia County, Kenya
District chairman Assistant chief administration officer (CAO)	Busia District, Uganda
District biostatistician	MOH, Busia District, Uganda
ART clinic in-charge, CBHU focal person	Busia Health Centre IV, Busia, Uganda
Site stakeholders—Malaba, Kenya; Malaba, Uganda	
Subcounty TB and leprosy program coordinator	MOH, Teso North Subcounty, Busia County, Kenya
Nurse, CBHU focal person	Malaba Dispensary, Malaba, Kenya
Comprehensive Care Center in-charge HTS provider CHA	Malaba Dispensary, Malaba, Kenya
PEs	Malaba Dispensary, Malaba, Kenya
Representative CAO	Tororo District, Uganda
District health officer (DHO)	Tororo District, Uganda
District health educator (DHE)	MOH, Tororo District, Uganda
District biostatistician	MOH, Tororo District, Uganda

Title	Organization
Site coordinator HTS coordinator	North Star Alliance (NSA) Wellness Center, Malaba, Uganda
Nurse, CBHU focal person, PEs	Malaba Health Centre III, Malaba Uganda
Site Stakeholders—Sio Port/Port Victoria, Kenya; Majanji, Uganda	
Subcounty medical officer of health SCASCO	MOH, Bunyala Subcounty, Busia, Kenya
Subcounty medical officer of health	MOH, Samia Subcounty, Busia, Kenya
SCASCO	MOH, Nambale Subcounty, Busia, Kenya
CCC in-charge (AMPATH)	Sio Port Subcounty Hospital, Busia, Kenya
Health records information officer	Sio Port Subcounty Hospital, Busia, Kenya
Facility in-charge	Lumino Health Centre III, Lumino Uganda
Assistant DHO	MOH, Namayingo District, Uganda
PEs	Sio Port/Port Victoria, Kenya and Majanji, Uganda
Site stakeholders—Muhuru Bay, Kenya; Kirongwe, Tanzania	
County director of health promotion Medical officer of health	MOH, Migori County, Kenya MOH, Nyatike Subcounty, Migori County, Kenya
Subcounty surveillance officer	MOH, Awendo Subcounty, Migori County, Kenya
Nurse, focal person CBHU, CHA, CBPEs, public health officer	Tagache Health Centre, Mahuru Bay, Kenya
District medical officer	MOH, Rorya District, Tanzania
District AIDS coordinator (DACC)	MOH, Rorya District, Tanzania
HCW, Male Ward, Data Clerk HCW, Maternity Ward	KMT Shirati Hospital, Shirati, Tanzania
Site stakeholders—Katuna, Uganda	
Acting DHO, former facility in-charge, Kamuganguzi Health Centre IV	MOH, Kabale District, Uganda
Facility in-charge	Kamuganguzi Health Centre IV, Katuna, Ugada
Site coordinator (former)	NSA Wellness Center, Katuna, Uganda
4 CBPEs and 2 HCWs	Kamuganguzi Health Center IV
Site stakeholders—Taveta, Kenya; Holili, Tanzania	
Community strategic focal person	MOH, Mwatate Subcounty, Taita—Taveta County, Kenya
SCASCO	MOH, Mwatate Subcounty, Taita—Taveta County, Kenya
Subcounty TB and leprosy coordinator	MOH, Mwatate Subcounty, Taita—Taveta County, Kenya
Clinical officer, CCC	Taveta Subcounty Hospital, Taita-Taveta, Kenya
CHA, PEs	Taveta Subcounty Hospital, Taita-Taveta, Kenya
Facility in-charge	Taveta Subcounty Hospital
Facility in-charge	Kitobo Dispensary, Taveta Subcounty, Kenya

Title	Organization
District medical officer	MOH, Rombo District, Tanzania
Facility in-charge(former),CBHU focal person	Holili Health Center, Holili, Tanzania
Nurse, CBHU focal person Data coordinator	AMEC Holili Dispensary, Holili, Tanzania
PE	Holili, Tanzania
CB-HIPP Nairobi staff and implementing partners	
Chief of party	CB-HIPP/FHI360
Implementation science advisor	CB-HIPP/FHI360
Knowledge management advisor	CB-HIPP/FHI360
Knowledge management technical officer	CB-HIPP/FHI360
Strategic relationship manager Africa regional director	Medic Mobile
Executive director	NSA
Senior associate/portfolio manager Healthcare financing specialist	Abt Associates
Acting executive director information and communication technology and communications Program assistant	FEAFFA

APPENDIX B. EVALUATION SCOPE OF WORK

MEASURE Evaluation Phase IV

Scope of Work for
CB-HIPP Performance and Costing Evaluation

May 15, 2019 – March 31, 2020

East Africa

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INTRODUCTION

The Cross-Border Health Integrated Partnership Project (CB-HIPP), led by FHI360 and supported by the U.S. Agency for International Development (USAID), commenced operations on September 1, 2014 with the goal of extending quality integrated health services in strategic border areas and other transport corridor sites and waterways in East Africa. CB-HIPP adopted an implementation science approach to programming and serves as a learning laboratory for testing and disseminating evidence-based models for cross-border health programming.

Regional stakeholders are currently conducting consultations to build consensus on the transition process for the Standard Package for Cross-Border Health Programming developed by CB-HIPP. Consultations will determine and clarify mandates as well as roles and responsibilities of key local, national, and regional stakeholders. As project activities transition, USAID/East Africa is interested in conducting a performance evaluation of CB-HIPP and assessing the cost of CB-HIPP programmatic scale up.

Background

East Africa and Southern Africa are the two regions most affected by the HIV/AIDS epidemic worldwide. East Africa alone is home to more than six million people living with HIV/AIDS. Women and vulnerable girls are a priority population particularly affected by HIV. In several East, Central, and Southern African countries, HIV prevalence among young women is up to five times higher than among men in the same age cohort. Paid sex also contributes to the current HIV epidemic in East Africa—specifically in hot spot communities along major transport routes. An estimated 14% of new HIV infections in Kenya and 10% in Uganda are associated with sex work (Gelmon et al. 2009; Wabwire-Mangen et al. 2009). Furthermore, these same women are affected by high rates of unintended pregnancies and must be reached with integrated family planning, reproductive health, and maternal health services, including prevention of mother to child transmission (PMTCT) (Ikamari et al. 2013; Elmore-Meegan et al. 2004).

Fisher folk in low and middle income countries worldwide constitute the highest risk group for HIV/AIDS (Kissling et al. 2005). Recent data from studies around lakes in the region indicate higher HIV prevalence among fisherfolk compared to the general population and with other groups generally considered at high risk of HIV infection (Opio et al. 2013).

Mobile individuals comprise another priority population with heightened risk for HIV. Studies have documented high rates of HIV infection among truck drivers in East, Central, and Southern Africa ranging from a low of 10% to a high of 56% (Ramjee & Gouws 2002; Delany-Moretlwe et al. 2014; Kissling et al. 2005; Bwayo et al. 1994; Mbugua et al. 1995). High-risk sexual behavior, including frequent unprotected sex with sex workers, alcohol abuse, gender-based violence, and anal intercourse with both women and men make these groups highly vulnerable to HIV infection (Morris & Ferguson 2007).

Meeting the needs of mobile and vulnerable populations in cross-border areas will require collaboration among stakeholders from different countries as well as regional policy and program approaches. The East Africa Cross-Border Integrated Health Study (MEASURE Evaluation, 2017) found that loss to follow-up plagued care and treatment programs at cross-border health facilities. Further, across all programs examined in the study—HIV, ANC, immunizations, PMTCT, and TB treatment—health facilities could not easily distinguish loss to follow-up from silent transfers to a new health facility, particularly if the health facility was on the other side of an international border. Healthcare workers at the facilities included in the study reported that the main barrier to developing a system for cross-border collaboration and patient referral was the lack of a mechanism

or platform to support such a system, which they believed could improve both retention in care and continuity of care.

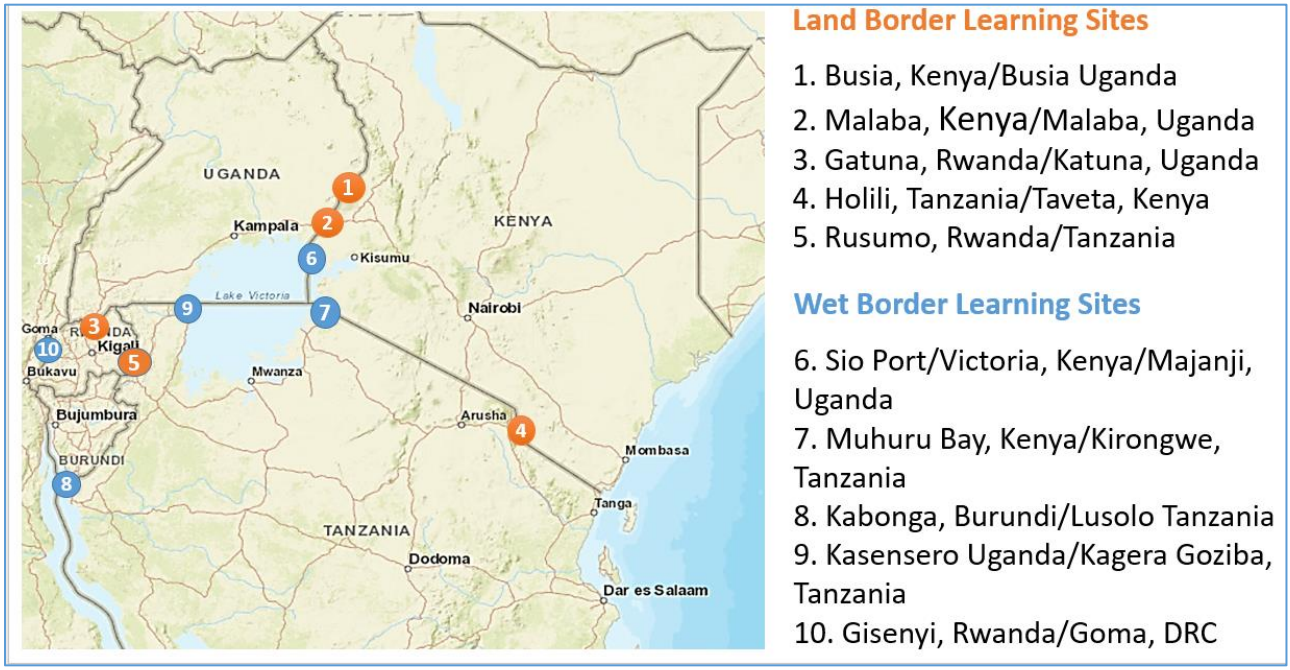
CB-HIPP

The three main objectives of CB-HIPP are to:

1) Increase access to and uptake of integrated health and HIV/AIDS services at strategic cross-border sites and select regionally recognized HIV transmission hotspots along East Africa transport corridors;
2) Identify, implement, and test alternative health-financing models to strengthen the long-term sustainability of health and HIV/AIDS service delivery; and
3) Strengthen the leadership and governance of intergovernmental institutions, so they can assist in improving the health of mobile and vulnerable populations.

The project focuses efforts on several mobile and vulnerable populations: female sex workers (FSWs), fisherfolk, truck drivers and migrant workers, men who have sex with men (MSMs), people who inject drugs, and vulnerable young women and girls. East African Community (EAC) regional stakeholders selected the ten land and wet cross-border locations listed below for initiation of CB-HIPP activities (see Figure 1). The project utilized a phased implementation approach for site-level activities given there was continuous partner state engagement and validation of sites after initial site selection.

Figure 1. CB-HIPP implementation sites 2014 – 2019



Standard Package for Cross-Border Health Programming in the East Africa Region

CB-HIPP has defined a Standard Package for Cross-Border Health Programming in the region that includes 7 components. They components are described below.

Functional coordination and collaboration system. This system ensures multi-sectoral buy-in and ownership to stimulate dialogue and development of responsive cross-border health policies; provides formal communication channels between County/District health management teams, (C/DHMTs) leadership and community structures; joint systematic oversight and advisory fora to review implementation of agreed-upon cross-border health processes.

Functional direct service delivery and referral system. This system ensures direct service delivery, facility-facility cross-border referral and communication, and strengthens facility-community linkages.

Cross-border digital health management information system. This system will inform development of a cross-border digital system that links facilities at border areas across borders making monitoring of mobile populations' access to HIV and other services at different health service delivery points in the region possible. Therefore, there is need for: a functional, digital interoperable care delivery and insights system and improved care delivery for mobile cross-border population and resident border communities; locally validated digital protocols and algorithms for HIV and TB management using WHO approved standards across East African partner states; and, an enhanced data platform capable of linking with the East African Community (EAC) DHIS2 data warehouse.

Portable heath care financing options/products. Portability of health insurance and financing options requires in-depth policy engagement across all levels. CB-HIPP's contribution will comprise of health financing studies to inform development of viable options and make policy recommendations. The project is not funded to introduce the products into the market.

Capacity strengthening on migration health. This component includes developing a regional toolkit with curricula and other materials on mobility and migration health for skills building and capacity on mobile and cross-border key and priority populations for C/DHMTs, frontline health care workers and community health workers/volunteers; orientation of health care providers on cross-border Partner States' health policies/guidelines, and facilitating mutual knowledge and understanding of Partner States health systems.

Learning and knowledge management. As a learning project, CB-HIPP is creating knowledge to strengthen the evidence base, facilitate the exchange/sharing of knowledge and use of evidence to inform design, implementation, and policies on cross-border health programming.

Policy and regulatory support. All cross-border actions require joint agreement among stakeholders for systematic learning and ownership of documented lessons to inform review and/or development of cross-border health policies. Each of the components of the cross-border health system has policy implication, requiring continuous engagement at local (County/District), national (Partner State) and regional (EAC) levels.

MEASURE EVALUATION PHASE IV OVERVIEW

The primary objective of MEASURE Evaluation is to enable countries to strengthen their systems to generate high quality health information that is used for decision making at local, national, and global levels. MEASURE Evaluation applies a systems approach to achieve this objective in a sustainable way. One application of this approach is to increase capacity for rigorous evaluation. MEASURE Evaluation's results framework reflects the overarching implementation strategy whereby the project works through distinct activities to achieve results. Achievements in the four result areas shown below contribute to the overall project objective.

Result 1: Strengthened collection, analysis and use of routine health data;

Result 2: Improved country-level capacity to manage health information systems, resources and staff;

Result 3: Methods, tools and approaches improved and applied to address health information challenges and gaps;

Result 4: Increased capacity for rigorous evaluation.

MEASURE Evaluation's work in this SOW will address *Result 4: Capacity building in rigorous evaluation* and related technical skills is primarily through collaborative implementation of these activities (learning by doing). As such capacity building is embedded in the process of implementing the activities.

The MEASURE Evaluation consortium brings together international experts in monitoring and evaluation from the University of North Carolina at Chapel Hill (UNC), Palladium, John Snow, Inc. (JSI), ICF International (ICFI), Management Sciences for Health (MSH), and Tulane University. MEASURE Evaluation experts have many years of experience with design and implementation of rigorous impact and performance evaluations, as well as interventions related to HIV and key populations.

4EA-004: CB-HIPP PERFORMANCE AND COSTING EVALUATION

Activity Leader: Emily Weaver
Other Staff: Lauren Morris, Shaylen Foley, Field Staff (TBD), Milissa Markiewicz, Khou Xiong, Kat Tedford

Summary

MEASURE Evaluation will conduct a performance evaluation focused on the 7 components of the CB-HIPP Standard Package for Cross-Border Health Programming, assess the costs of CB-HIPP programmatic scale up, convene a regional cross-border workshop, and recommend Standard Package components for scale up.

Objectives

A. *Conduct a performance evaluation*. MEASURE Evaluation will examine the CB-HIPP Standard Package for Cross-Border Health Programming and identify and document lessons learned and recommend scalable best practices. A performance evaluation will focus on each of the 7 components of the Standard Package. For each component, the evaluation team will:

1. Determine what worked well and what did not work so well;
2. Determine satisfaction of key stakeholders and the extent of their buy-in;
3. Examine contextual factors that facilitated or hindered the success of the component.

The evaluation team will also generate time trends for relevant CB-HIPP performance indicators for each of CB-HIPP's six sites (Busia, KE/UG; Malaba, KE/UG; Sio Port/Port Victoria, KE and Majanji, UG; Muhuru Bay, KE and Kirongwe, TZ; Taveta, KE and Holili, TZ; and Katuna, UG) and will gather stakeholders' views on how CB-HPP contributed to changes in these indicators overtime, as well as how CB-HIPP added value to national and regional health interventions.

B. *Assess the cost of CB-HIPP programmatic scale-up*. MEASURE Evaluation will also assess the cost of CB-HIPP programmatic scale-up, including the development of a model to project various scale-up scenarios (comparison of scale-up under an international implementing partner *vs* a local organization, as well as an international implementing partner providing technical assistance to a local organization).

C. *Convene a regional, cross-border workshop*. MEASURE Evaluation will work with USAID/East Africa and regional partners to convene a regional cross-border dissemination workshop. MEASURE Evaluation, together with the CB-HIPP and the Global Partnership for Sustainable Development Data (GPSDD), and in collaboration with USAID/East Africa, will assist in planning and participating in a regional, cross-border dissemination workshop. This regional workshop will bring together representatives from EAC member countries, other key governmental and non-governmental stakeholders, PEPFAR, USAID, Centers for Disease Control (CDC), and other U.S. Government implementing partners. The group of coordinating partners will contribute the necessary materials for the workshop and share costs in organizing the workshop. The goal of the workshop is to gather recommendations to support development of the Journey to Self-Reliance (J2SR) Roadmap for a "Standard Cross-Border Health Programming Model." MEASURE Evaluation will produce draft reports and PPT slides for presentation at the regional event for three studies: CB-HIPP Performance and Costing Evaluation (4EA-004), TB/HIV and Mobility Study (EA-003), and the EAC Digital Health and Interoperability Assessment (4EA-005). During the regional workshop, consensus will be reached on recommendations related to each of the three studies. Following

the workshop, the draft reports for each of the three studies will revised and finalized to incorporate relevant consensus recommendations.[5]

Components A and B

Component A. Performance Evaluation

A performance evaluation will be conducted to produce information about CB-HIPP's Standard Package for Cross-Border Health Programming, which is comprised of 7 components. Methods for the performance evaluation will include document review and qualitative key informant interviews and/or small group interviews. We anticipate gathering qualitative data at eight sites to include national stakeholders in Nairobi, Kenya and Kampala, Uganda (e.g., Ministry of Health officials, USAID/East Africa, and CB-HIPP's implementing partner, FHI360), as well as local stakeholders (e.g., C/DHMTs and facility in-charges) at six cross-border sites (Busia, KE/UG; Malaba, KE/UG; Sio Port/Port Victoria, KE and Majanji, UG; Muhuru Bay, KE and Kirongwe, TZ; Taveta, KE and Holili, TZ; and Katuna, UG). The evaluation team will also attempt to interview regional stakeholders (i.e., the EAC Secretariat in Burundi) by phone.

Interview guides will be developed to guide interview discussions regarding the 7 components. The guides will contain questions about relevant CB-HIPP performance indicators to ensure that successes and challenges related to the indicators are identified. Key informant and small group interviews will be systematically analyzed, summarized, and synthesized to identify 1) what worked well and what did not work so well, 2) the extent to which key stakeholders were satisfied with and bought into each component of the Standard Package, and 3) contextual factors that facilitated or hindered the success of each component and the overall implementation of the package. Time trends for the relevant CB-HIPP performance indicators will be generated for each study site and integrated into the final report.

Component B. Costing Study

The primary aim of the costing study is to assess the cost of CB-HIPP programmatic scale-up, including the development of a model to project various scale-up scenarios. Included in the scenarios will be a comparison of scale-up under an international implementing partner vs a local organization,[6] as well as an international implementing partner providing technical assistance to a local organization. The following questions will need to be addressed:

1. What is the vision for scaling-up? How would the scale-up look if it were successful? Which components would be used to implement the intervention at scale?
2. What are the necessary resources (e.g., human skills, financial, information technology, etc.) for scaling up the interventions? What will be the short- and long-term cost considerations of scale-up? How will the necessary support be mobilized?

The cost estimation phase of the assessment will include a costing questionnaire, collection of cost data, and a scale-up cost estimation model/tool. These tools will be completed via in-person meetings, conference calls, and email with implementers. MEASURE Evaluation will obtain detailed information on the structure and function of the CB-HIPP program, including the break-down of the seven Standard Package components.

[5] Findings from 4EA-002: CB-HIPP Special Studies will also be presented at the workshop. Note that 4EA-002 is a completed activity and the study report has already been finalized.

[6] A potential local organization is Wavuvi Concern (Lake Victoria Consortium for Health Research) that brings together Uganda Virus Research Institute (UVRI-Entebbe), Kenya Medical Research Institute (KEMRI-Kisumu) and Mwanza Intervention Trials Unit (MITU-Mwanza)

Relevant information will be extracted from written program documentation and supplemented by email and dialogue. This information will be used to inform the mapping of costs to the seven components and begin to understand the cost of the various processes involved in the CB-HIPP program.

Retrospective data collection will be conducted using an ingredients approach to apply current value to recurrent inputs and an annualized value to capital inputs. Cost and program data will be collected from multiple sources including budgets, work plans, expenditure summaries, accounting/financial accounts, and timesheets as relevant. The costing assessment will use a step-down costing approach, which takes existing, program-wide financial record data and portions it appropriately to various intervention activities. In the case of this activity, the aim will be to identify intervention costs and assess how these costs align with program inputs as they fall along the seven components. The level of variation in detail of the financial accounts over the phases of program implementation may limit the level of comprehensive costing we are able to conduct.

Costs of the originating program will be supplemented with other factors, including economies of scale, diseconomies of scale, resource substitution, personnel allocation, and intervention modification (based on general parameters and assumptions). Key assumptions will be tracked in the model used to estimate the cost of scale-up scenarios. The number and level of assumptions that will need to be made will depend on the cost data that we are able to gather from the implementers of the originating program.

The development of the scale-up cost estimation model/tool will be an iterative process, considering the scenarios and parameters which are most feasible, probable, and have funding potential. We will also collect cost data from a local organization to inform general parameters including salaries/LOE, indirect costs, and ODCs. The more information we can collect from the local organization the fewer assumptions will need to be made. Capacity is an important challenge in local institution settings, where trained researchers with the necessary analytical skills are scarce, often making data collection difficult. This activity will include inherent capacity building with the local organization to improve their understanding of expenditure data and its use in decision making (especially that of USAID).

MEASURE Evaluation has developed a similar model for estimating the cost of programmatic scale-up for various scenarios previously. This model was developed for a Special Initiatives funded process evaluation in Southern Africa assessing the scalability of integrated Orphan and Vulnerable Children (OVC) programming with pediatric treatment and prevention of mother-to-child transmission (PMTCT). The model allows for an unlimited number of scenario testing, with the input of additional parameters. Additionally, the project has an ongoing activity focused on case management (the platform upon which OVC services are delivered) to gain insight into current approaches to case management delivery, the cost of those approaches, and to explore the context of case worker costs and perceived quality of case management delivery. We have used the 4Children process-based definition of case management as the framework for the activity and are mapping case management costs to the seven components. These experiences and tools can be applied to this activity.

Cost data collection and KIIs with CB-HIPP and local organization staff are dependent on coordination with the USAID/East Africa. The Mission is also expected to provide support in the development of scale-up scenarios and parameters, particularly around understand which are most feasible, probable, and have funding potential. The successful collection of cost data is also dependent on coordination and collaboration with CB-HIPP, including that they provide the requested information to inform the mapping of costs to the seven components and to understand the cost of the various processes involved in the CB-HIPP program. CB-HIPP will also need to participate in KIIs. The scale-up model and estimation of scale-up costs will require coordination and collaboration with a local organization. They will need to provide the requested information to inform the scale-up model and parameters including salaries/LOE, indirect costs, and ODCs and participate in KIIs.

Benchmarks and Deliverables

The following benchmarks highlight what the project will achieve by the close of project.

Benchmark 1: Finalize study concept

Benchmark 2: Finalize plans for the regional, cross-border dissemination workshop within available budget[7]

Benchmark 3: Develop tools for the performance evaluation of the CB-HIPP Standard Package for Cross-Border Health Programming

Benchmark 4: Collect data for the performance evaluation

Benchmark 4: Develop data collection tools for the costing study and collect data from CB-HIPP and a local organization

Benchmark 5: Establish parameters for the scale-up model/tool and conduct any necessary follow up data with CB-HIPP

Benchmark 6: Analyze data and write draft report integrating findings from the performance evaluation and costing study

Benchmark 7: Finalize the report and disseminate findings

[7] Linked to activities: 4EA-002; 4EA-003; 4EA-005. Available budget is currently $125,000 to support travel/participation of key stakeholders associated with each of the four MEASURE Evaluation East Africa regional activities.

PROPOSED TIMELINES AND DELIVERABLES[8]

Tasks	Responsible Party	2019								2020				Deliverable
		Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
4EA-004 CB-HIPP Performance Evaluation														
Benchmark 1. Finalize study concept	EW, LM		X											
Benchmark 2: Finalize plans for the regional, cross-order dissemination workshop	KT		X											
Benchmark 3: Develop tools for the performance evaluation of the CB-HIPP Standard Package for Cross-Border Health Programming.	EW, MM		X	X	X	X								
Benchmark 4. Collect data for the performance evaluation								X	X					
Benchmark 4. Develop data collection tools for the costing study and collect data from CB-HIPP	LM, SF			X	X									
Benchmark 5. Establish parameters for the scale-up model/tool and conduct any necessary follow up data with CB-HIPP	LM, SF					X								
Benchmark 6. Analyze data and write draft report integrating findings from the performance evaluation and costing study	EW, LM					X	X	X	X	X	X			

[8] Benchmarks and deliverables timelines are subject to approval timing and availability of funds.

Tasks	Responsible Party	2019									2020			Deliverable
		Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Benchmark 7.[9] Finalize the report and disseminate findings	EW, LM											X	X	• Slide deck • Dissemination meeting • Finalized report *(post dissemination meeting)*
EW = Emily Weaver; Lauren Morris – LM; MM = Milissa Markiewicz, KT = Kathleen Tedford														

[9] This deliverable corresponds with activities: 4EA:002, 4EA-003 & 4EA-005's EAC regional dissemination event in February 2020.

STAFFING

Emily Weaver, PhD is the activity lead and PI for the evaluation. She is responsible for the overall development of the evaluation design as well as implementation of the evaluation. She will have primary responsibility for collaboration with local partners and consultants. Dr. Weaver is a Research Associate for the MEASURE Evaluation project based at the Carolina Population Center. She has worked for over 10 years in research and evaluation of public health programs with expertise in maternal, newborn and child health. At MEASURE, Emily is leading evaluations of RMNCH programs in Tanzania and Malawi and worked on a key populations program for HIV in Namibia. She has worked on impact evaluations for the Feed the Future FEEDBACK project, specifically evaluating the impact of integrated agricultural value chain and nutrition interventions on health outcomes in Malawi and Guatemala. Other work includes curriculum development, and technical capacity building in impact evaluation and in measurement of maternal mortality using various data platforms in Africa and Asia. Dr. Weaver earned a PhD in Health Policy and Management from the UNC Gillings School of Global Public Health and a Master of International Affairs from the University of California, San Diego.

Lauren D. Morris, PhD will lead the costing component of the evaluation. She is a Technical Advisor at Palladium/MEASURE Evaluation. She has a PhD in Mineral Economics from the Colorado School of Mines; and a Master's in Economics from Boston University Her background is in economic impacts of public policy, including public health policy and economy-wide impacts of environmental policy. Her technical areas of expertise include: economic evaluation including costing and cost-benefit analysis; building and applying policy models that project costs and benefits of intervention and inform advocacy efforts; mathematical modeling, including operations research approaches and computable general equilibrium models; health financing, and qualitative analysis.

Field Staff, (TBD). S/he will assist in cost data collection from CB-HIPP and conduct follow-up with CB-HIPP as necessary. S/he will also assist with establish parameters for the EAHRC.

Milissa Markiewicz, MPH, PMP will provide project management support to the evaluation, including recruitment and hiring of consultants and/or subcontractors. Ms. Markiewicz is currently a Research Associate at UNC's Carolina Population Center (CPC), and has served as project manager/research associate on several evaluations under MEASURE Evaluation and Feed the Future in Uganda, Malawi, Botswana, Rwanda, Kenya, Tanzania, and Zambia. She previously served as project manager for the SE Region of the Network for Public Health Law and as a program director at the Terry Sanford Institute of Public Policy at Duke University. Ms. Markiewicz worked in Uganda for over three years as an academic director and special projects coordinator for the School for International Training.

Khou Xiong, MPH, is a research associate at the University of North Carolina, providing technical assistance and program management support across multiple studies on the MEASURE Evaluation project. Xiong will assist with data collection for the performance evaluation. She often contributes to overall study design and development, stakeholder engagement, ethical review procedures, contracting, oversight of fieldwork, data management, analysis, report writing and dissemination. She has 9 years of experience in public health in low-to-middle income countries; including Guyana, Jamaica, Jordan, Kenya, South Africa, Syria, Tanzania and Uganda. Her work in public health incudes research in water sanitation and use, family planning, sexual reproductive health, HIV/AIDS, and mHealth applications to improve health systems. Her MEASURE

Evaluation portfolio also includes monitoring and evaluation, organizational network analysis, operational research studies, data quality assessments, priorities for local AIDS control efforts studies, and process and impact evaluations.

Local Consultant (TBD) A local consultant will be hired to assist with logistics in country for the five site visits associated with the performance evaluation.

Kathleen Tedford, MPH is a Country Portfolio Manager. She provides oversight and support to the MEASURE Evaluation team throughout the implementation of this activity. She will monitor compliance with MEASURE Evaluation Phase IV Agreement conditions, reporting requirements, and approved work plan deliverables. She is the primary contact for communications with USAID/W. Ms. Tedford has more than 12 years of experience in global health across 30+ countries. Prior to coming to MEASURE Evaluation, she has worked within mHealth, informatics and tech start-up space in global health and disease surveillance programming. She has conducted qualitative research studies in cultural barriers to care-seeking behavior, provided TA in HMIS, mHealth, GIS and M&E to Ministries of Health, and managed USAID funded projects in maternal and child survival initiatives. Ms. Tedford holds a master's degree in public health, with an emphasis in maternal and child health.

Table 1. Travel Detail

Traveler	Departing City	Departure Date	Destination	# of Days	Description
Lauren Morris	Chapel Hill, NC	June 2019	Nairobi, Kenya	7	Collection of cost data from CB-HIPP and to inform finalization of the scale-up estimation model
Lauren Morris	Chapel Hill, NC	July 2019	Nairobi, Kenya	7	Establish parameters for the scale-up model/tools and conduct necessarily follow-up with CB-HIPP
Emily Weaver	Chapel Hill, NC	August/ September 2019	Nairobi, Kenya	7	Data collection for the modified performance evaluation
Milissa Markiewicz	Chapel Hill, NC	August/ September 2019	Nairobi, Kenya	30	Data collection for the modified performance evaluation
Khou Xiong	Chapel Hill, NC	August/ September 2019	Nairobi, Kenya	30	Data collection for the modified performance evaluation
Emily Weaver	Chapel Hill, NC	February 2020	Kisumu, Kenya	7	Dissemination
Lauren Morris	Chapel Hill, NC	February 2020	Kisumu, Kenya	7	Dissemination

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APPENDIX C. DATA COLLECTION TOOLS

CB-HIPP – Cost Data Collection

Date: 4 November 2019

7 program components:

Functional coordination and collaboration system

Functional direct service delivery and referral system

Cross-border digital health management information system

Portable healthcare financing products/options

Capacity strengthening on migration health

Learning and knowledge management

Policy and regulatory support

Chief of Party (Deputy) or Technical Director

Describe the program briefly

What is the purpose/goal of the program

Who are the sub partners and responsibilities?

Please describe how well you think the program is achieving its goals

Please describe program management activities

Please describe how the 7 program components are implemented

What was the timeline of implementing the 7 components?

Finance staff

Have there been prior cost assessments or evaluations other than EA?

EA reporting:

Please describe your current process for reporting to the EA

Where does the data come from? What information is aggregated and how?

Please describe how you determine which expenses belong in the EA expenditure categories

Financial systems structure

Please describe how FHI 360 CB-HIPP tracks costs and expenses

Do you have multiple reporting systems? What data is contained where?

How do you get data from subpartners? When? In what format?

How frequently is data reported to these systems?

How and when are you receiving financial/expenditure data from subpartners?

Which subpartners work on which components?

How aggregated is the data?

Do you do any checks for data quality? Please describe

Please describe any weaknesses of the current system

Are there costs/expenses incurred that are not tracked in the current system? Volunteer time, donations, etc?

Do the financial tracking systems/processes link to other data tracking? Such as outcomes, interventions?

Request assistance with

Inventories of buildings/equipment

Commodity/procurement records

Staffing/labor costs records, timesheets, help understanding work on program and program components

How many program staff works on [program]? See examples below and provide the titles and number of staff on the program

- Technical
- Program management
- Community Health Worker/field staff
- Grants
- Finance/Admin
- HR
- Procurement

Trainings – dates, number of attendees, intervention focus, costs by category (food, space, travel, hotel, staffing – who performs training?)

Meetings (same details as trainings)

Other costs not tracked

Assigning costs to program components

M&E

Please describe any on-going research of the program

Please describe any data tracking systems in place – has this been linked to cost?

Please describe how the program is tracking outcome data

What resources are used for M&E? Computers, forms, staff, etc

Scale-up:

What is the vision for scaling-up?

How would the scale-up look if it were successful?

Which components would be used to implement the intervention at scale?

What are the necessary resources (e.g., human skills, financial, information technology, etc.) for scaling up the interventions?

What will be the short- and long-term cost considerations of scale-up?

How will the necessary support be mobilized?

Local IP:

Salaries/LOE

Indirect costs

ODCs

Capacity

Would it be possible to estimate start-up costs (What types of start-up costs would be needed? Hiring, opening offices) vs. recurrent and capital costs? If yes, please provide these start-up costs.

Would you be able to provide a breakdown of the expenditure categories you are tracking expenditures by? If yes, please provide the breakdown.

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about the **Cross-Border Coordination and Collaboration System** as you have been identified by CB-HIPP as having experience with this component for their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID
- Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component I: Cross-Border Coordination and Collaboration System

A. Background

1. Please tell me how you were involved with the coordination and collaboration efforts of CB-HIPP. At which level?

2. How does the Cross-Border Coordination and Collaboration System you have experience with function?
   - What purpose was the Cross-Border Coordination and Collaboration System created to serve?
   - Who are the members of 1) the system? 2) the Coordination Team?
   - Who is the lead the agency/stakeholder (who leads the consultations)?
   - Were terms of reference/guidelines developed for the Coordination Team? If so, can you briefly describe them?
   - What priority cross-border actions were identified by the system? How were they identified?
   - How was implementation and progress on priority actions monitored?

3. How does the Cross-Border Coordination and Collaboration System benefit the following:
   - Target population (mobile, cross-border key and priority population groups)?
   - Healthcare providers?
   - Other stakeholders?

B. What worked well and not so well

1. CB-HIPP has identified a process for creating and maintaining creating and maintaining a Cross-Border Health Coordination and Collaboration System. I would like to know what worked really well in implementing each activity, and what was challenging. I will read each activity. If you were not involved in a particular activity, you can tell me and we will go on to the next step.

   - Identifying existing structures at different levels of policy and decision-making such as D/CHMTs.
   - Identifying a lead agency/stakeholder such as MOH to lead the site level, inter- and intra-country cross-border multi-sectoral consultations for buy in and ownership at the policy and service delivery levels.
   - Establishing terms of reference/guidelines to guide the undertakings of the Coordination Team.

- Identifying priority cross-border health actions (policy, advocacy, and practice) to address the unique needs of cross-border mobile key and priority populations. This includes joint planning by Coordination Teams at the cross-border site level.
- Providing joint systematic oversight to monitor progress in implementation of identified joint priority actions. This includes regular planning and review meetings, supervision, etc.

2. I would like to know how effective the system has been in obtaining results. I will read some intended results to you. For each, please tell me what factors facilitated or hindered achievement of the result.

   - Stimulating dialogue and development of responsive policies related to cross-border health?
   - Providing formal communication channels between stakeholders related to cross-border health?
   - Identifying joint priority actions related to cross-border health?
   - Implementing joint priority actions related to cross-border health? (Probe: What specifically was achieved?)
   - Monitoring and evaluating joint priority actions related to cross-border health?

C. Satisfaction of stakeholders

1. Overall, how satisfied are you with how the Cross-Border Health Coordination and Collaboration System has/is functioning?

Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied

   - What do you find most valuable about the system (probe for examples)?
   - What would you want to change about the system?

2. In your opinion, should stakeholders invest in continuing the Cross-Border Health Coordination and Collaboration System after CB-HIPP? Why or why not?

3. In your view, does the Cross-Border Health Coordination and Collaboration System that you have experience with have the capacity to maintain the Cross-Border Health Coordination and Collaboration System without additional support from CB-HIPP? If no, what support is needed?

   - Technical support?
   - Financial support?

D. Contextual factors that facilitated or hindered success of this component

1. What are the main contextual factors that have facilitated or hindered the success/effectiveness of the Cross-Border Health Coordination and Collaboration System? Probe for examples:

    - Political facilitators or hindrances (e.g., different national policies and guidelines)
    - Cultural facilitators or hindrances (e.g., language differences)
    - Norm/value facilitators or hindrances
    - Other facilitators or hindrances (e.g., border controls)

E. Other

1. Is there anything else you would like to tell us about the Cross-Border Coordination and Collaboration System?

General Questions

1. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP contributed directly or indirectly to these indicators.

    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

2. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:

    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as regional TB surveillance; regional HIV interventions; and regional population, health and environment (PHE) interventions. (Please give examples)

Thank you!

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about **Functional Direct Service Delivery and Referral System: Cross-Border Health Units (CBHUs)** as you have been identified by CB-HIPP as having experience with this component of their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID
- Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component II: Functional Direct Service Delivery and Referral System: Cross-Border Health Units (CBHUs)

A. Background

1. What is your experience with CBHUs? (How have you been involved with a CBHU?)

2. In your view, what challenges/gaps do CBHUs address?

3. How do CBHU's benefit mobile, cross-border key and priority populations? (What unique needs do these populations have that are addressed by CBHUs?)

4. Who are key members of the CBHU team and how do they interact? (What are their roles?)

5. Please tell me more about the Cross-Border Health Services Directory.
   - How does it support cross-border health service delivery?

B. What worked well and not so well

1. Were you involved in the development of a CBHU? (*If NO, skip to Question 2*).

   - [*If YES*] There were key activities involved in developing a CBHU. Which activities you were involved in and how were you involved?

     [Mark "X" beside activity if respondent mentions it in his/her response. Include description of his/her response]

ACTIVITY	**"X"** (if mentioned)	**DESCRIPTION OF INVOLVEMENT**
1. Conducting a site assessment		
2. Identifying potential health facilities		
3. Holding a consultative meeting with the respective C/DHMT's HCWs		
4. Identifying CBHU teams at participating health facilities		

5. Orienting teams on the CBHU model		
6. Establishing quarterly/bi-annual joint cross-border meetings and learning exchanges		
7. Developing a schedule for health outreaches at hotspots		
8. Monitoring cross-border health service delivery and referral		

- Which activities were easiest to carry out and why?
- Which were most challenging to carry out and why?

2. Please tell me:
   - Which aspects of the CBHU model do you think work really well? (And why?)
     Probe for same activities above.
   - Which aspects of the CBHU model have not or are not working so well? (And why?)
     Probe for same activities above.
     - What could be done to make those aspects work better?

3. I am going to read you a list of results. For each, please tell me whether the CBHU contributed (or not) to each, and if so, how. What factors facilitated or hindered achievement of the result?

   - Identifying mobile key and priority population members
   - Increasing the number of mobile key and priority population individuals who received HTC and received their test results (case identification)
   - Increasing the number of adults and children newly enrolled on ART, or currently receiving ART (linkage to care)
   - Increasing the number of adults and children who are still on treatment at 12 months after initiating ART (retention in care, including tracing defaulters and LTFU)
   - Increasing the number of individuals who have received TB screening services
   - Improving the TB treatment success rate
   - Conducting peer education outreach sessions by CBPEs
   - Increasing the number of CHWs providing family planning information and/or services during the year
   - Reducing discontinuation of family planning
   - Increasing the number of people reached by GBV services (e.g., health, legal, psychosocial counselling, shelters, hotlines, other)

- Increasing the number of people receiving post-GBV clinical care
- Increasing the number of people who completed PEP services (related to sexual violence services provided)
- Increasing the percentage of HIV service delivery points that are directly providing integrated voluntary family planning services
- Increasing the number of facilities linked to cross-border referral system (strengthening cross-border referrals and community facility linkages)

C. Satisfaction of stakeholders

1. How satisfied are you with the CBHU you have experience with?

Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied

   - What do you find most valuable about CBHUs (probe for examples)?
   - What would you want to change about your CBHU?
2. How satisfied are other stakeholders with the CBHU model and to what extent do they feel ownership of it? (*Provide example based on respondent, e.g., respondent's cross-border counterpart or other members of the CBHU team.*)

Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied

   - What evidence or examples can your provide?

3. In your opinion, should the CBHU be continued after CB-HIPP? Why or why not?

4. Do CBHU teams and other stakeholders have the capacity to maintain CBHUs without additional support from CB-HIPP? If no, what support do they need?

   - Technical support?
   - Financial support?

D. Contextual factors that facilitated or hindered success of this component

1. What were the main contextual factors that facilitated or hindered the creation or function of CBHUs? Probe for (give examples):

   - Political facilitators or hindrances (e.g., different national policies and guidelines)
   - Cultural facilitators or hindrances (e.g., language differences)
   - Norm/value facilitators or hindrances
   - Other facilitators or hindrances (e.g., border controls)

E. Other

1. Is there anything else you would like to tell us about CBHUs?

General Questions

3. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP contributed directly or indirectly to these indicators.

    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

4. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:

    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as regional TB surveillance; regional HIV interventions; and regional population, health and environment (PHE) interventions. (Please give examples)

Thank you!

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about **Cross-Border Digital HMIS** as you have been identified by CB-HIPP as having experience with this component of their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID

Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component III: Cross-Border Digital HMIS

A. Background

1. Please describe your experience with the cross-border health management system/tools and processes developed by CB-HIPP for CBHUs. Probes:

    - What data was tracked?
    - How was it tracked? What tools were used for tracking?
    - How was the data used?

2. Do you feel there is a need for the manual system to be made digital/electronic and interoperable (across borders)?

    - What gaps are there in the manual system that can be reduced or eliminated by a digital, interoperable system?

3. [*For specific stakeholders only, see stakeholder list*] Are you involved in the pilot cross-border digital HMIS on the Kenya-Uganda border? (If NO, go to Question 4).

    If YES:

    - What is the scope of the pilot? (e.g., Is it meant to serve only CBHUs, or will it have broader use?)
    - Who are the key stakeholders involved?
    - How best can the pilot be evaluated?
    - If the pilot is successful, what would it achieve/accomplish?
    - If the pilot is successful, what do you see as the logical next step?

4. Please tell me more about the Cross-Border Health Services Directory.
    - How does it support the manual system that currently exists?
    - Do you think it should be incorporated into the digital interoperable HMIS?

B. What worked well and not so well

1. With regard to the manual system, what has worked really well that you feel is essential to incorporate into a digital interoperable HMIS?

2. What key lessons did you learn from implementing the manual system that could be helpful to the development of the digital interoperable HMIS?

3. I am going to read some results. For each, please tell me how effective the manual system has been in obtaining the result. What factors facilitated or hindered achievement of the result?

    - Tracking community health-referrals?
    - Tracking cross-border facility-facility referrals?
    - Identifying mobile key and priority populations?
    - Tracing defaulters and LTFU?

4. How do you envision a digital interoperable system will improve on these results? Probe for each.

C. Satisfaction of stakeholders

1. Who would you say are the main stakeholders for a digital interoperable HMIS? Probe for:

    - Site level
    - National level
    - Regional (EAC) level

2. How well would you say these stakeholders buy into the need for cross-border digital interoperable HMIS? (What evidence or examples do you have?)

3. [*For specific stakeholders only, see stakeholder list*]: With regard to the pilot in Uganda/Kenya, how satisfied have you been with the way the pilot has been introduced?

D. Contextual factors that facilitated or hindered success of this component

1. What were the main contextual factors that facilitated or hindered the development of the manual data management system? How will these factors facilitate or hinder the development of an interoperable HMIS? Probe for (give examples):

    - Political facilitators or hindrances (e.g., different national policies and guidelines)
    - Cultural facilitators or hindrances (e.g., language differences)
    - Norm/value facilitators or hindrances
    - Other facilitators or hindrances (e.g., border controls)

E. Other

1. Is there anything else you would like to tell us about the need for or the development of an interoperable HMIS?

General Questions

5. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP contributed directly or indirectly to these indicators.

    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

6. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:
    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as regional TB surveillance; regional HIV interventions; and regional population, health and environment (PHE) interventions. (Please give examples)

Thank you!

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about development of a **Portable Health Care Package** as you have been identified by CB-HIPP as having experience with this component of their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID
- Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component IV: Portable Health Care Package

A. Background

1. How have you been involved in CB-HIPP's efforts to develop a portable health care package?

2. Please tell me a little bit more about the need for a portable health care package and the problem it seeks to address. How will a portable health care package benefit mobile, cross-border key and priority populations?

3. What are some of the solutions/options being considered with regard to a portable health care package?

    - Which of these solutions is most promising in your view?

4. What do you think should be the next steps that need to be undertaken to move the process of developing a portable health care package forward?

B. What worked well and not so well

1. With regard to the various work completed to date to develop a portable heath care package, what has worked well to move the process forward?

    - Probe for: conducting studies? Sharing results of studies? Engaging stakeholders?

2. What hasn't work so well to advance the process? What challenges have there been?

3. I am going to read you some results. Please tell me how effective you think CB-HIPP has been in achieving each. What factors facilitated or hindered achievement of the result?

    - Identifying alternate health financing models?
    - Implementing alternate health financing models?
    - Testing alternate health financing models?
    - Packaging and disseminating operations research findings to inform policy formulation?

C. Satisfaction of stakeholders

1. Who are the key stakeholders that would need to be involved to take the process of developing a portable health care package forward? Probe for:

- Site level
- National level
- Regional (EAC) level

2. Have stakeholders been satisfied to date with the work on this component? Specify stakeholders.

Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied

- What value has it brought them?

3. In your view, are the stakeholders committed to moving the process of developing a portable health care package forward? Why or why not? (What evidence or examples do you have?)

4. Do stakeholders have the capacity to move the process of developing a portable health care package forward without additional support from CB-HIPP? If no, what support do they need?

- Technical support?
- Financial support?

D. Contextual factors that facilitated or hindered success of this component

1. What were the main contextual factors that facilitated or hindered CB-HIPP in their efforts to conduct and disseminate research findings to inform policy related to a portable health care package? Probe for (give examples):

- Political facilitators or hindrances (e.g., different national policies and guidelines)
- Cultural facilitators or hindrances (e.g., language differences)
- Norm/value facilitators or hindrances
- Other facilitators or hindrances (e.g., border controls)

E. Other

1. Is there anything else you would like to tell us about the development of a Portable Health Care Package?

General Questions

7. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP contributed directly or indirectly to these indicators.

    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

8. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:

    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as regional TB surveillance; regional HIV interventions; and regional population, health and environment (PHE) interventions. (Please give examples)

Thank you!

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about **Capacity Strengthening on Migration Health** as you have been identified by CB-HIPP as having experience with this component of their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID
- Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component V: Capacity Strengthening on Migration Health

A. Background

1. How have you been involved in CB-HIPP's efforts to strengthen the capacity of HCWs and CHWs on migration health?

2. Please tell me a little bit more about the need for capacity strengthening on migration health and the problem it seeks to address.

    - What skills/knowledge are HCWs and CHWs lacking?
    - How does capacity strengthening for migration health benefit mobile, cross-border key and priority populations?

3. Please tell me more about the peer educator/migration health/HIV Workplace module curriculum [*specify based on respondent*].

    - What topics are covered?
    - What is the means of delivery (in person training, mentoring, other), etc.?
    - Who is using/implementing the curriculum?

4. In addition to the curriculum discussed above, CB-HIPP carried out other activities to strengthen capacity for migration health. We would like to know how important you think each is to ongoing capacity building for migration health:

    - MOH-led HCWs training (joint cross-border trainings where feasible) on provision of integrated health services targeting mobile and cross-border key and priority populations;
    - Integration of mobility with key and priority populations service provision topics in facility-based continuous medical education sessions (CME);
    - Encouraging the use of digital platforms like WhatsApp to promote collaboration across CBHUs;
    - Sharing of border counterpart SOPs, treatment guidelines, and other health service delivery tools to facilitate mutual understanding for improved cross-border health service delivery and referral, as well as identification of areas for harmonization/standardization.

B. What worked well and not so well

1. What aspects/means of capacity strengthening have worked especially well? (And why?)

2. What aspects/means of capacity strengthening have been challenging or not worked so well?

(And why?)

3. I am going to read you some results. Please tell me how effective you think capacity strengthening has been in obtaining the following results. What factors facilitated or hindered achievement of the result?
   - Improving HCWs' and CHWs' attitudes towards and ability to respond to the unique needs of mobile key and priority populations?
   - Improving provision of integrated health services targeting mobile key and priority populations?
   - Improving knowledge of border counterpart SOPs, treatment guidelines, and other health facility service tools?

C. Satisfaction of stakeholders

1. How have HCWs and CHWs responded to efforts to improve their capacity in migration health? Probes:
   - Have they found it valuable (what examples do you have)?
   - Do they believe there is a need for capacity strengthening in this area?

2. Has there been improvement in relations between HCWs/CHWs and mobile, cross-border key and priority populations? (What examples do you have?)

3. Do stakeholders have the capacity to continue implementing the capacity strengthening activities we have discussed without additional support from CB-HIPP? If no, what support do they need?

   - Technical support?
   - Financial support?

D. Contextual factors that facilitated or hindered success of this component

1. What were the main contextual factors that facilitated or hindered the implementation of capacity strengthening activities? Probe for:

   - Political facilitators or hindrances (e.g., different national policies and guidelines)
   - Cultural facilitators or hindrances (e.g., language differences)
   - Norm/value facilitators or hindrances
   - Other facilitators or hindrances (e.g., border controls)

E. Other

1. Is there anything else you would like to tell us about capacity strengthening for migration health?

General Questions

9. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP contributed directly or indirectly to these indicators.

    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

10. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:
    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as regional TB surveillance; regional HIV interventions; and regional population, health and environment (PHE) interventions. (Please give examples)

Thank you!

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about **Learning and Knowledge Management** as you have been identified by CB-HIPP as having experience with this component of their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID
- Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component VI: Learning and Knowledge Management

A. Background

CB-HIPP's Learning and Knowledge Management strategy contained several approaches/methods for generating and/or disseminating evidence. These included:

- National and site entry meetings
- Consultative processes
- Baseline and formative assessments
- Data validation meetings
- Guidance documents
- Program implementation/documentation of lessons
- Conference presentations
- Technical reports
- Articles/book chapters
- Policy and technical briefs
- Webinars
- Other

1. How were you involved in CB-HIPP's Learning and Knowledge Management activities?

2. In your view, how do CB-HIPP's Learning and Knowledge Management activities benefit mobile, cross-border key and priority populations?

B. What worked well and not so well

1. Which of the methods/approaches previously mentioned were most effective for generation of knowledge? (Why were they effective?)

2. Which of these methods/approaches were most effective for dissemination? (Why were they effective?)

3. Which of these methods/approaches were least effective for generation of knowledge? (Why were they not so effective?)

4. Which of these methods/approaches were least effective for dissemination? (Why were they not so effective?)

5. I am going to read some results. Please tell me how effective you think CB-HIPP's Learning

and Knowledge Management activities have been in obtaining each. What factors facilitated or hindered achievement of the result?

- Creating knowledge to strengthen the evidence base with regard to:
  - Mobility and its impact on access to health services
  - Availability, demand, and access to cross-border health services
  - Health seeking behavior of mobile cross-border key and priority populations in East Africa
  - Policy environment for cross-border health
  - Heath care financing
- Facilitating the exchange/sharing of knowledge to inform design/implementation and policies on cross-border health programming? (Probe separately for each: design/implementation and policies)

6. What gaps in knowledge remain with regard to creating knowledge to strengthen the evidence base with regard to the topics we just discussed?

D. Satisfaction of stakeholders

1. Who are the key stakeholders/audience for dissemination of Learning and Knowledge Management? Probe for:

   - Site level
   - National level
   - Regional (EAC) level

2. Have stakeholders been supportive of providing CB-HIPP with inputs and information? (Probe for examples)

3. Have stakeholders provided feedback about any of the products produced under this component?

   - Which products have gained the most traction? Why do you think this has been the case?

4. What evidence/examples can you provide regarding the <u>use</u> of learning/knowledge developed by CB-HIPP for:

   - Design/implementation of cross-border health programming (independent of CB-HIPP programming)?

- Policy development for cross-border health programming?

E. Contextual factors that facilitated or hindered success of this component

1. What were the main contextual factors that facilitated or hindered Learning and Knowledge Management activities? Probe for (give examples):

   - Political facilitators or hindrances (e.g., different national policies and guidelines)
   - Cultural facilitators or hindrances (e.g., language differences)
   - Norm/value facilitators or hindrances
   - Other facilitators or hindrances (e.g., border controls)

F. Other

1. Is there anything else you would like to tell us about the Learning and Knowledge Management?

General Questions

11. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP contributed directly or indirectly to these indicators.

    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

12. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:

    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as regional TB surveillance; regional HIV interventions; and regional population, health and environment (PHE) interventions. (Please give examples)

Thank you!

Interview Guide for CB-HIPP Stakeholders

Thank you for participating in this interview about CB-HIPP and cross-border health programming.

We are interested in talking with you about **Policy and Regulatory Support** as you have been identified by CB-HIPP as having experience with this component of their work.

We would like to discuss how the component was developed, what worked well and not so well, and the extent of stakeholder satisfaction. We are also interested in understanding any contextual factors that facilitated or hindered the effectiveness/success of each component.

We will end with some general questions on CB-HIPP and how their work has contributed to national/local programming and improvement in indicators related to HIV, TB, and family planning.

NOTE for Interviewer (definition of target population):

Mobile, cross-border populations to include:

- Key populations include FSWs, MSM, and PWID
- Priority populations include truckers, cross-border traders, clearing and forwarding agents, vulnerable women and young girls, fisherfolk, and other mobile groups.

Component VII: Policy and Regulatory Support

A. Background

1. How have you been involved in CB-HPP's policy and regulatory support activities?

2. In your view, what policy engagement is needed to support cross-border health? Probe for:

    - Support needed at the district/county level (form who)
    - Support needed at the national level (from who)
    - Support needed at the regional level (form who)

3. How have the results of CB-HIPP's policy and regulatory activities benefitted mobile, cross-border key and priority populations?

4. What ongoing policy and regulatory support is needed to effectively support cross-border health?

B. What worked well and not so well

1. In your view, what activities has CB-HIPP carried out to effectively engage policy makers at the:
    - County/Sub-County/District level?
    - National (Partner State) level
    - Regional (EAC) level?

2. In your view, what activities have not worked very well to engage policy makers at the:
    - County/Sub-County/District level?
    - National (Partner State) level
    - Regional (EAC) level?

3. I am going to read some results. Please tell me how effective you think CB-HIPP's policy and regulatory support has been in obtaining each. What factors facilitated or hindered achievement of the result?

    - Galvanizing political commitment and leadership in support of cross-border health
    - Creating a supportive policy and regulatory environment for cross-border health
    - Galvanizing resource allocation for cross-border health
    - Optimizing adoption of best practices for cross-border health

C. Satisfaction of stakeholders

1. In your view, who are the main stakeholders associated with policy and regulatory support?

2. How have they shown support for CB-HIPP/cross-border health throughout the project? (What evidence can you share that exemplifies support for CB-HIPP/cross-border health?)

D. Contextual factors that facilitated or hindered success of this component

1. What were the main contextual factors that facilitated or hindered CB-HIPP in engaging policy makers in support of cross-border health? Probe for (give examples):

    - Political facilitators or hindrances (e.g., different national policies and guidelines)
    - Cultural facilitators or hindrances (e.g., language differences)
    - Norm/value facilitators or hindrances
    - Other facilitators or hindrances (e.g., border controls)

E. Other

1. Is there anything else you would like to tell us about policy and regulatory support?

General Questions

13. USAID is particularly interested in a specific indicators related to HIV, TB, and family planning. Please tell me how CB-HIPP's Standard Package contributed directly or indirectly to these indicators.
    - Identifying new cases of HIV
    - Linking PLHIV to care
    - Improving retention in care and treatment adherence
    - Increasing the number of PLHIV who are virally suppressed
    - Improving the TB treatment success rate
    - Reducing discontinuation of family planning

14. Please tell me how CB-HIPP's Standard Package/cross-border health model adds value to:
    - Local/national health interventions? (Please give examples)
    - Regional health interventions, such as; regional TB surveillance, regional HIV interventions and regional population, health and environment (PHE) interventions. (Please give examples)

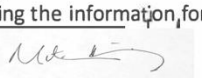
Thank you!

APPENDIX D. CONFLICT OF INTEREST STATEMENTS

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Milissa Markiewicz
Title	Research Associate
Organization	MEASURE Evaluation
Evaluation Position?	Team member
Evaluation Award Number *(contract or other instrument)*	AID-OAA-L-14-00004
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Cross-Border Integrated Health Partnership Project, FHI360 AID-623-L-14-00001
I have real or potential conflicts of interest to disclose.	☐ Yes ■ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature 
Date March 31, 2020

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Emily Weaver
Title	Research Associate
Organization	MEASURE Evaluation
Evaluation Position?	Team leader
Evaluation Award Number *(contract or other instrument)*	AID-OAA-L-14-00004
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Cross-Border Integrated Health Partnership Project, FHI360 AID-623-L-14-00001
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Signature	Emily H. Weaver
Date	March 31, 2020

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Lauren Morris
Title	Technical Advisor
Organization	MEASURE Evaluation
Evaluation Position?	Team member
Evaluation Award Number *(contract or other instrument)*	AID-OAA-L-14-00004
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Cross-Border Integrated Health Partnership Project, FHI360 AID-623-L-14-00001
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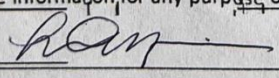
Signature 

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Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Khou Xiong
Title	Research Associate
Organization	MEASURE Evaluation
Evaluation Position?	Team member
Evaluation Award Number *(contract or other instrument)*	AID-OAA-L-14-00004
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Cross-Border Integrated Health Partnership Project, FHI360 AID-623-L-14-00001
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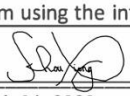
Signature	
Date March 31, 2020	

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