



# LEARNING FROM THE CAPITALISATION PROCESS OF WEHUBIT PARTNER PROJECTS IN E-HEALTH

Call for Proposal #3

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*What are the lessons learned regarding the design, implementation and sustainable use of a digital social innovation in the health sector in East Africa? How do we support sustainable pathways for innovation in the health sector?*

The Wehubit projects all worked towards the same long-term objective: **being integrated into the Ministry of Health (MoH)**'s ongoing/planned priorities and actions, by **aligning with the government's needs, processes and/or formal strategies**.

To successfully integrate or, for now, collaborate and promote ownership, Wehubit projects have given time to design their digital social innovation with the MoH and/or other key users. Here are the most important **lessons learned and recommendations** drawn from the experience of the four Wehubit projects that participated in the capitalisation process on e-health.

## **Mama Rescue project: Transportation that saves the lives of Mothers and Babies**



Uganda



By



From 12/2019 to 06/2023



Learning Sheet



**23,959** women in labor have been transported from their homes to health facilities in the Kyotera and Rakai Districts.

## **The machine learning project: Using AI and machine learning to personalize and improve perinatal health in Zanzibar**



Zanzibar, Tanzania



By



From 12/2019 to 05/2022



Learning Sheet



**93%** of women that were identified as high-risk received at least one additional CHV visit.

## **SafeCare and openIMIS project: Transforming Zanzibar's Health system**



Zanzibar, Tanzania



By



From 01/2020 to 12/2021



Learning Sheet



**800.000** citizens from **165.000** households are enrolled in the openIMIS system.

## **MediCapt project: Technology in the service of justice**



Democratic Republic of Congo



By



From 12/2019 to 12/2022



Learning Sheet



**870** cases of sexual violence against women have been documented via MediCapt in the framework of the Wehubit.

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**Communicate towards the Ministry of Health (MoH), before starting and throughout implementation, on the digital social innovation and provide evidence of its added value with very concrete, tangible potential outcomes.**

Evidence can take diverse forms:

- ▶ Based on the specific phase in the process and/or previous experiences of implementation, projects can conduct a pilot phase with a proof of concept
- ▶ Develop and share capitalisation products based on former experiences
- ▶ Refer to national, regional and international institutions frameworks regarding the leverage of new technologies to strengthen your narrative

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**Communicate and get the buy-in from key actors within the decision-making continuum before starting implementation.** On the one side, at **government level** to integrate the innovation in the national landscape. On the other side, at **local level** – districts and community leaders - to make the innovation acceptable to the stakeholders who are the closest to the beneficiaries and build legitimacy.

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**Integrate the innovation into existing processes and tools** to prevent fragmentation. Two main risks are identified if the innovation does not take what is already existing and used into account: (1) It further aggravates the lack of a **coordinated answer to the identified challenge**, jeopardizing the innovation's potential impact and (2) Users – public actors, health facilities...– eventually drop the innovation or never **use the new data available**, although useful. Thus, projects should not overlook the following:

- ▶ Integration into existing processes must **not hinder the quality** or **threaten the security of data**. As health projects are mainly dealing with personal (sometimes very sensitive) data, they must carefully evaluate if existing processes or tools, e.g. facilities' management tools, can integrate their innovation without breaching privacy.
- ▶ Integrating innovation is an **iterative process that requires flexibility and time**, which is often not incorporated into existing collaboration and/or funding procedures. Indeed, projects must identify where their innovation fits best and adapt it based on what already exists. This requires a great deal of interaction and knowledge about internal MoH's procedures and tools, but trust and open communication is not always high, because it has not yet been built, in the design phase.

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**Discuss the capacity sharing needs with the users – at all levels (organisations, public actors from top to local, communities) - and plan it from the start.** Capacity sharing pursue several objectives. By working with the MoH or other strategic partners to develop the skills to develop, manage and sustain the digital innovation helps to ensuring that the **innovation remains sustainable beyond project's end**.

Besides, capacity sharing facilitates users' ownership of the digital innovation. In some cases, being trained to use the digital tools have worked as an incentive for (end-) users to adopt the innovation as it offers them new skills.

Capacity sharing of users collecting the data (CHVs, medical staff, enrolment staff...) also ensures that the "do no harm" principle is respected throughout the process. This principle is important to promote as all Wehubit projects in health are dealing with personal (sometimes very sensitive) data, collected from (sometimes very) vulnerable groups.



## Training of trainers

At local level, training end-users (CHVs, health care workers enrolment staff...) can consume a great deal of time and resources as staff turnover and drop out can be high. One solution used by some projects is to identify master trainers and follow a “**training of trainers**” strategy. This solution also has value regarding sustainability, as these master trainers will be able to continue training others beyond the project’s end.

However, it is less feasible when the skills needed are too technical or the beneficiaries/users too sensitive. For example, in order to use the MediCapt application, clinicians must receive **comprehensive trainings and regular refreshers** to ensure proper use with survivors of sexual violence, who are a population with unique needs. New user members must be fully trained before using the app as improper use (either in the app itself or with clinical procedures) could cause harm to survivors.

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**Discuss data governance \* with the MoH and other partners from the start.** In this regard, it’s important to verify (1) if a local legal framework exists in the implementation country and (2) if so, that it regulates data management and privacy, especially if dealing with personal, sensitive data.

In addition to a legal framework, it’s important to have a clear agreement with the government and/or other stakeholders about **data ownership, data security, data use** and **sustainability**. These need to be addressed and mutually agreed upon before the project starts. Especially when dealing with personal, sensitive data, a clear agreement will ensure responsible use of data, in line with the “do no harm” principle. This agreement also ensures transparency to the users and people whose data are collected.

\* See Wehubit AI checklist

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**As the data collected and produced will directly support the users (MoH, medical staff, project team...), data should be displayed and valued through visualisation tool(s) that answers the needs and is user-friendly.** Depending on projects, visualisation tools can be developed at diverse levels: facilities, regional, national... The implication of the project in the **development, adaptation and management of these tools** should be discussed with partners, and, if need be, capacity building and an exit strategy should be planned from the start.

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**All actors (MoH, NGO’s, national and international donors...) bear some responsibilities in giving transparency about who is doing what in the health sector, and in building synergies.** At NGO’s level, projects can actively engage with other actors from the ecosystem to set up collaboration or explore areas common use of the (part of) the digital innovation, in order to **pool resources, leverage impact** and/or **prevent fragmentation**.

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**A digital social innovation in health should always be focused on one (or one package of) specific health or health service-related objective and answers specific needs of specific users.** One innovation cannot solve everything with regards to achieving universal health coverage. Therefore, in addition to building synergies, it’s the responsibility of projects to **know the ecosystem and take it into account**.

This implies:

- ▶ Understand the existing ecosystem and reality in the country/district before introducing a digital innovation, to avoid raising **beneficiaries' expectations** that won't be met in the short or midterm. For example, linking marginalised citizens to public hospitals for better care is useless and harmful if these public hospitals are not able to offer the care needed.
- ▶ Consider the state of **infrastructure** and **resources** while designing innovation. For example, Internet connection and electricity are still quite unstable in the areas of the four Wehubit projects concerned. Working with affordable, low tech and/or offline tools can be a solution.
- ▶ While planning for capacity building, be aware that partners will not necessarily be able to hire the the most appropriate profiles for the job, because of procedures (especially in public institutions) or realities of the job market. When it comes to **technical digital skills**, training is important but technical support from external stakeholders (NGO's or private sectors vendors) should also be considered.
- ▶ Make the project's results and the data available to develop **knowledge** and **awareness** in the whole chain of actors that are or should be involved in a comprehensive solution.



### Community health volunteers as drivers of change

A Community Health Volunteer \* (CHV) is a member of a community who is chosen by community members or organisations to provide preventive and/or basic health and medical care within their community.

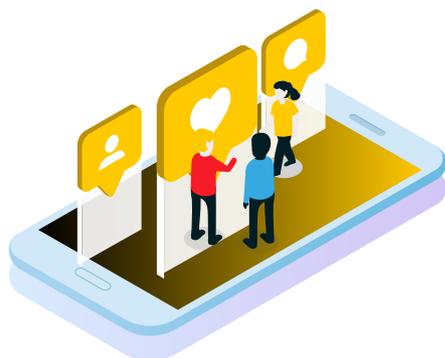
Most Wehubit projects in e-health have integrated CHVs in their digital social innovation, either as user, recipient or support. In all these projects, CHVs play an important role, at local level, as **drivers of change** (change of behaviour of the target group and of its perception of health issues/realities). They play the role of **ambassadors** of the project and of the innovation.

CHVs usually don't have a higher education degree in health. They are selected on recommendations by local leader and communities' members based on several criteria: being **legitimate** and **respected** in the community, living in the place for more than 5 years, speaking the local languages...

Their role is, on the one hand, to promote health and **bridge the gap** between communities and health facilities. On the other hand, ensure continuous communication towards and buy-in from the communities, give feedback to the project's team and address context specific and cultural barriers.



\* Other terms for this type of health care provider include community health officer, community health worker, village health worker, community health aide, community health promoter, and health advisor.



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