

Financial Times Africa Consultation

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This summary was prepared by the Commission Secretariat based on notes offered by Mr Andrew Jack. Comments from the discussion have been anonymised.

Key Takeaways

- 1) Intersection of private and public sectors:
 - a. What do PPPs mean now? It is often that a PPP should focus on the exchange of knowledge within DH, as well or instead of money or contracts. Without technocrats, private companies will not have the regulatory environments to flourish.
 - b. Regulation and policy are essential because without these tools there is little ability for patients to trust digitally enabled health care; this is especially relevant for marginalized groups whom require autonomy, and without trust first in government will get left behind.
 - c. When considering how governments should invest in digital health, it is essential to go beyond digital health interventions. At the risk of essentializing, the following example provides a difference which can unravel larger power structures at play: One participant spoke of how they have to integrate into their business model the cost of paying physicians to train them on how to use their technology. On the one

hand, to them, this is not ideal. On the other hand, this makes sense when working for a public health care system that has not paid the physicians in the past 7 months. In this situation, digital health becomes hard to be realized in the private sector with these overhead costs. This example can also extend to a lack of electricity in health settings, etc.

- i. In terms of larger power structures, what is at stake in this construction is:
 - i) a culturally 'sanitized' Euro-American centric notions of how a return on investment should be realized;
 - ii) colonial legacies of underfunded health systems, and
 - iii) a lack of ability for private, public, and philanthropic sectors to implement horizontal programs.
- 2) The role of the private sector
 - a. Take the first step initiating public sector engagement.
 - b. Through the use of digital, private sector actors claim that there is increased trust
- 3) The role of the public sector
 - a. Build ICT Ministry capacity.
 - b. Provide regulation which ensures donor provision of sustainability, or funding for the government to build ICT capacity which will make the intervention sustainable (Tanzanian model).
 - c. Some suggested that Mpesa is a good model for digital health in Africa. This requires several characteristics. i) Fostering an innovation 'sandbox' whereby governments work to coordinate and promote interoperability between innovations. ii) Focusing on long term investments, approaching investment horizontally and not only vertically. (Note the difference in investment temporalities between finance and health care sectors which may serve as a rate limiting step here).
- 4) Analysis, critical viewpoints and open questions
 - a. A participant noted how we need to stop calling it digital health, and start calling it increased access to health care enabled through digital technology.
 - b. There was consensus that the COVID-19 pandemic has strengthened the role of digital health, and participants suggested that it also expanded the role of health from beyond the clinic to other features of public health. More critically, one participant astutely noted that, while it has advanced digital health, we need to be cautious of how many of these solutions are here to stay? In other words, beyond this particular event, we may not need many of the specifics of COVID-19 technologies in non-pandemic times, and that is often overlooked in the currently large investments being made.
 - c. There is a tension between the role of the private sector in wanting to put in the newest innovation, but inevitably generating a digital divide. For example, one attendee spoke of how, in a hospital which only had one room with internet, they built a telemedicine consultation centre. Of interest here is the question of which

socioeconomic groups in the area where a hospital only has one room with internet might have access to these services. The 'digital divide' is not just about increasing access to services overall, but increasing them in an equitable way.

- d. Digital technologies are extremely gendered (says US development organization) and it is important to build out the patriarchy by building feminism into implementation design.
- e. A US development organization, and others echoed similarly, how these organizations are looking to learn from youth to support the goals of their products. The tokenism and one sidedness of this approach must be noted. While many organizations claim that they want to make youth 'true partners' there is no tangibility to what 'true' or 'partner' or 'equal' means and values are often revealed through the explicit stating of actors like this in that they wish to **"use"** youth to increase "free market economics."

Detailed Discussion (quasi verbatim)

- What is a Lancet Commission? They usually look at medical issues, but this commission is looking at the governance of digital health. Specifically, those which do not get access to health care and the role that digital health can play in that.
- This is the first time that FT and Lancet have done a commission to focus on digital health, technologies to accelerate UHC. The focus is on children, young people, and LMICs. During the deliberations there are issues around data, governance, and infrastructure, and the tendency is to focus on developed countries and the systems that exist there. The Commission has done a good job of bringing forward the opportunities that exist within Africa. Out of the 20 youngest countries, 19 are in Africa. There is a lot of room to do something with young people and young companies. There is a focus on data rights: individual or societal? Human rights. UHC. There are so many areas to be covered, especially because it is a new area, and with COVID we know there are huge potentials to leverage digital technology.
- In recent years, digital technologies and advances in AI and data have unlocked several innovations in health care, which have ultimately led to improved health outcomes. Private-sector actors are looking to achieve UHC goals, and technology is one of the main levers to improve delivery systems, while ensuring that quality is not compromised. The pandemic helped to highlight how accessible technology is. Advances in telemedicine have helped to improve delivery but also acceptability from the users as well, because it is a valid option users are open to. Even though the pandemic is destructive, it has provided a platform to leapfrog the use of technology and improve health outcomes on the continent.

- To think about use cases, the global management sector has seen the following for patients: self-management care, monitoring, digital health acceleration; for health providers: telemedicine, training, and other technologies which help to support areas that have been underserved due to limited resources; and for governments: tracing and emergency cooperation, workforce management, supply chain management to ensure there is minimal stock, there are so many different use cases.
- We see many examples of mobile money across Africa. We are hoping that the initiatives we see today will help us to improve equity, so that no one is left behind, regardless of the basis of age, gender, and the things that we see today. We should talk about the impacts and potentials to help us achieve UHC, but also what are the core enablers to help us stimulate this innovation so that we are able to achieve UHC in a fair and acceptable manner.
- The private telecom sector in certain African countries has in the past partnered with various organizations. What they are looking at is unlocking the delivery of affordable, accessible and quality healthcare, and putting this in the hands of everyone, as well as looking at that from a digital health perspective.
- At the onset of mobile money (such as M-Pesa), financial inclusion was below the 20% mark in Kenya. Due to M-Pesa it is now at 9 out of every 10 Kenyans. For 90% we are shifting from not just talking about inclusion, but going into financial health. When telecommunications providers look at what they did with Mpesa, their provocation is how do they deliver, how do they leverage technology to make a fundamental difference in health care. Kenya is seriously under indexed in terms of doctors to patients. 8 out of 10 lack access to health care. From a telecommunications perspective, they want to understand how to make a fundamental difference in that space in digital health.
- Some non-profit organisations are focusing on using simple technologies such as SMS, USSD, to connect patients to improve health and health outcomes. Patients are supported with information that help them to care for themselves to go to the right services at the right time. Health professionals are assisted with training support. From health workers and patients national departments of health get critical information on how the healthy system works. This allows things to reach a very large scale. One such project helps 80% of mothers giving birth in South Africa each year, and 33000 nurses are connected through that program. COVID-19 has been an accelerator for DH, and non-profit actors have been able to launch programs to provide information and prevent misinformation, which have even taken up by WHO globally for WhatsApp and messaging, and have been rolled out to other ministries of health in Africa. It provides information as well as allows them to check their risk for COVID-19. That is provided to the national health ministries. It has been amazing to see how quickly people have

adopted digital services in the time of COVID-19. There has been a shift from resistance to willingness to adopt technologies.

- Over the last few months the importance of PH actors has dramatically accelerated. The social ramifications have been quite extensive. The clinical management has not been as pronounced as other types of crisis. So the government sector has had an important place much more than other epidemics. The technologies that come to the fore are then not only clinical management. That has been important.
- According to practicing physicians, patients with non-communicable diseases are faring poorly at government hospitals. This was happening at progressively younger ages. We are finding that adults in late teens are developing high BP. Medical practitioners have started to be able to bridge the gap. Some are able to provide counselling online to the youth in two slums. Digital health tools should respect youth privacy so that they should know who they are, where they are headed, so that they can take charge of their lives. Privacy is the right to choose ones thoughts and feelings and whom to share them with or not to share them at all.
- Global health initiatives have developed a symptom assessment technology, to come up with a solution for people to understand and manage their health. It is now possible to input symptoms into a Q and A format that are processed by an accurate and complete medical reasoning engine. Such innovations can be leveraged to increase overall access, especially in settings where medical resources are scarce. With COVID-19 the importance of leveraging resources is even more critical. Such technology is a digital front door to primary health care. Personalized health assessments help to determine what to do empower individuals. Overall the aim is to accelerate health care and make it more affordable, and also more accessible.
- It is also important to think about how mobile technology can connect people to health care technology. Mobile technology makes health care payments transparent and predictable, by integrating three parties, the payers, providers, and users. This creates a trust which ultimately lowers the overall cost of care. COVID has accelerated this. We need to use more money more efficiently within health care. This is why we need digital technology. That is the key to getting to UHC.
- Methodologies, data, and tech can be leveraged for people living with chronic health needs as well as short-term health needs. Digital health social enterprises are focusing on lifestyle changes that will provide an impact upon people's health. They have been able to demonstrate improvement in self efficacy i.e. an individual's belief that changing their behaviour is necessary to improve health outcomes. The power of digital can be seen when trust is built with users by providing convenient, non-judgemental access.
- The best way to use technology is to make sure that each time we deploy or use technology, it is contextual and that it is fit for purpose. Long term decisions, or

decisions that have a long term impact, should not be made because of a temporary situation like COVID. Technologies ought not to be COVID specific, they will not be relevant after the pandemic is over.

- The challenge is using not using digital health technologies efficiently, but the capacity of caregivers, the capacity of the people receiving care. It is the capacity and the lack of information.
- Individuals coming from most developing countries are receiving support from international development areas. As far as the 1980s-90s, most initiatives were fragmented in such a way that there are very few scaled. So come countries came to the approach that they have to initiate a digital health strategy, which is a document that guides the initiatives in the country. But the digital requirements of the entire country are not clear.
- It is also important to ask how we can improve health outcomes through digital technologies in the patriarchal world that we live in. Any innovations need to consider the gender inequality in which they will operate, and bring in young women and girls into the planning, development, and implementation. There is gender inequality in terms of access to health and information. But there is also a digital gender divide. Boys are more likely to have a mobile phone. Boys are more likely to have smart phones and have more access to information. In instances where young women have access to platforms, even though they have access, and read about reproductive health, relationships, etcetera, they do not act on this information because there is no trust, there is a fear of stigma, there is a fear of discrimination. They know about these things but they do not rust them.
- In countries like Kenya, Ghana, and Malawi, UN Women has equipped and empowered activists with knowledge, who themselves started platforms and spoke about communities where health information is not isolated to individuals. These women could engage with communities, doctors, lawyers, policy makers. The respondents said that they have daily contact with their peers through WhatsApp groups, which is a very simple tool. We need to bring these people to the centre of the intervention, young women and girls at the centre of the gender divide. Have them at the table for interventions that concern their own health.
- From a market-based approach, how do we reach youth where they are and how they like to engage? One area has been human centred design to better understand where youth are online and how they are engaging with content. It focuses on providing reproductive health information to teens and young people in an informative and engaging format, such as avatars and other gamification, in case for people which would otherwise not be able to receive access.

- Youth actors can be some of the capacity builders that we are looking for on the continent. They can show us the way that access can help us increase access to more users. They understand their needs best.
- From a regulatory perspective, the balance between regulation and innovation is important. For the government it is the convergence of digital technologies, and health, and health care, in order to enhance health care. So for regulation it has to be digital health. In Kenya there are 15 laws and policies that govern the space, and this could be a regulatory nightmare and minefield. The 6 key areas that have to be considered are i) what is licensed, ii) how do you govern data, iii) how do you deal with legal prescriptions, v) what is the compliance with lab services, and more. Innovation may be running ahead of innovation. So our proposal is thinking about a sandbox idea where you recognize and test some of those. Thinking the same way as Mpesa did, where the regulators enabled. There wasn't a deliberate sandbox but it was the same principal. If you sandbox, enable people to test, learn, and then refine regulation.
- One key thing is that digital health has everything to do with technology, and everything to do with health care. Every tool that doctors would carry in their bag, digital is one more, just like the stethoscope. What this should do is increase access for the care providers so that we can empower patients. But what is clear as well to me is that health care is a relationship between the patient and the care giver. That relationship is what has to be fostered. Anything that develops that relationship improves health care and improves outcomes. That relationship is what has to be the focus of digital health care. Hospitals, labs, testing machines are just diagnostic. Even the placebo effect that it has is to do with the trust with the doctor. We focused a lot on the video element, we have tried to see how we can have video between patient and caregiver, because it allows more communication through nonverbal communication. When the video element comes into the conversation, what we do to bridge the gap of inability of patients to be able to access is that we actually begin with resource centres, the model we have adopted is a facility based telemedicine. What we did last year with a grant from Pfizer is to show how we enable a level 2 health centre which had internet in only two rooms and we started that room as a digital diabetes and hypertension clinic. They would refer those patients that needed a physician on a weekly basis to that clinic. We were able to see those patients visually and verbally, make prescriptions and have medicine delivered. The human centred design is really key. That human centred design is something that we learned at the spring accelerator.
- Definitely in terms of creating that enabling environment, policy in regards to setting the right incentives for leveraging digital health solutions is key. One example from our space on the policy level or industry coming together, in our case when you look at symptom checking and the technologies that are out there, it is important to have the

regulatory frameworks in place in order to ensure policy makers and decision makers on the health side have the right guidance. This is on a local level, a regional level and a global level to create the environment for these tools to be able to be leveraged. This differentiation between digital health versus health. It is a means to and to accomplish better health outcomes.

- Three quick points: if you are doing accessibility it is also about affordability. In the African context people need to put more focus on UHC. Digital health, of course people have mobile phones, but it is a shame if people can't afford the health care. People are very poor. Second, there is an importance to regulations. Without these people get nervous about what the regulation is, and what they will do. So both the investor and implementer are clear on what the regulations are. The final thing is about data. In many countries, at least seeing this in Africa people are very conscious on where data is stored. It is important because you are looking at the security of the data. If that is the intention, you have to think about is my data better stored in the country or in the cloud. All these people that have AWS and more secure data, there is a conversation of physical and country location of data.
- Telemedicine projects are not sustainable because they become the point of compensation. For instance, a specialist sitting in health centre A attending a remote patient in location Z, the consultation allowance is being paid by insurance is paid to location Z, but the specialist in a remote area is not paid anything. So it prescribes them to come, but they are not being compensated by the time.
- As the innovators we must actively engage with the policy and regulators. If you look at the parallels with Mpesa, the private sector played a very proactive role. If you leave it only to the policy makers they may not have the insights that we have to do good. Innovation will only unleash the value if it reaches scale. What enables us to unleash the power of innovation is to have meaningful analyses of this data.
- If we look at the various points around the ethical application of technology. There are concerns about why data is hosted from mobile phones offshore. But upon assessment of local hosting options, it is found that hosting in country is more expensive and leads to lower quality of service. But if you think about all of these challenges they are to do with the regulatory and policy framework is not anywhere near catching up with the technology and knowledge of the players. The people at this table, when they sit down with public sector, they have more knowledge. So until the implementation side of things begins to invest in building capacity in lawmakers we will continue to have a regulatory framework that stifles innovation. So we might want to think about a new PPP, not money or contracts but knowledge changing hands so that your business can thrive.
- On the policy comments there also needs to be a lot of investments building the number of people working in ICT in the ministries. Everything is digital now, so that investment is

important. Another speaking to how pilots start and then stop. We should really start being intentional about testing these models, and the sustainability models, and how they are implemented. Mpesa came because that level of investment came in and a business model came about. With digital health there is fragmentation and not enough investment in any one area. So it is important to identify what is needed to be able to say that we will pay for this service as the government because it results in long term patient outcomes. So there is a disconnect between the payers and the innovators. So that way there is a flow of investment back into the ecosystem.

- First, capacity building. If we really want to invest in innovation. If we want to have technocrats with knowledge, the reality is we have to reinvest in our education system. We have to relook at investing our secondary school caution, and so that we are actually producing people that produce and contribute. We need people who have the capability in higher skilled areas. We have to look beyond to find specialists for our design, but how about fixing the devices, or helping to fix the devices for low income people. So who are those skilled players and how do we build that capacity so we are not continuously looking outside of this content. The other piece too is building on the idea of the business model. Many people in this space is that we are just as intentional around demonstrating a population health impact as we are about demonstrating a scalable financial impact. A lot of these challenges are there because of how investment in health have been done for the past decades. The fact that health care providers are expected to be paid for a training, this is on the one hand ludicrous, but is also reasonable when they have not been paid in the past 7 months. We need our policy makers to think holistically about health, about how this can potentially affect the market dynamic, and we need to have our policy makers to think about this. This requires policy makers to think beyond digital health.