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Healthcare Providers' Perceptions of Cross-Border Healthcare Services Utilization: A Qualitative Inquiry in the Tanzania-Uganda Borderlands

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Abstract

Available literature on cross-border healthcare services utilization focuses on borders outside the African continent and on the healthcare seekers' experiences. As such, there is limited understanding of this phenomenon along and across African borders and from the healthcare providers' perspectives. We conducted a qualitative study in the Tanzania-Uganda borderlands to understand healthcare providers' perceptions of cross-border healthcare utilization behavior and practices. Findings indicated healthcare providers have been caring for clients from across the border and face different challenges including in-house and professional standards, policy, laws and treatment guidelines dilemmas. However, healthcare providers have established different ways to minimize the impacts of these challenges. It is concluded border-crossing for healthcare services utilization will increase challenging traditional understanding of public health as state-confined and an important agenda on international health policy debates. It is recommended conduction further multidisciplinary research on cross-border healthcare services utilization-related issues to inform efficacious and border regions-friendly health initiatives in Africa.

Key Words: Cross-Border Healthcare Utilization; Cross-Border Health Seeking Behavior; Tanzania-Uganda Border; Borderlands; Borderlanders; Tanzania

Introduction

Existing literature on cross-border healthcare services utilization indicates two gaps that inform this paper. First, much of the literature present experiences from borderlands outside the African continent: US-Mexico, European and the Asian borders. As a result, there is limited understanding of this phenomenon along or across borders in Africa except South Africa and little is known on the impact of cross-border health-seeking behavior and practices to involved countries' healthcare systems, peace and security. Second, the literature pays much attention to healthcare services consumers' (migrants and transnational medical consumers/medical tourists) factors, perceptions, practices and challenges they face when accessing healthcare services at home and in neighboring or afar countries. Consequently, there is limited understanding of cross-border healthcare services utilization from the healthcare providers' perspective the world over [1], but more so in Africa and particularly across the Tanzania-Uganda border.

In the course of serving patients from neighboring or distant nation state(s), healthcare providers face several challenges including difficulty identifying border crossers (migrants, irregular migrants and undocumented migrants) from residents, communication and cultural barriers, heavy workload on already strained personnel, budget constraints and limited working space leading to overcrowding and burn out. Others are poor adherence to the regimen that is difficult to follow-up because border crossers are always on the move, are hard to reach in their home countries and some clients provide false information to

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hide their identities [1,2,3]. Some scholars have reported cross-border healthcare services utilization,

> [A]n economic win-win situation for transnational medical consumers and medical providers ... [Consumers] access needed medical procedures and medications, and the medical industry thrives [bringing] tremendous growth in the healthcare sector in [receiving states] [4].

Homedes, et al., (2016)'s observations suffice to demonstrate why the understanding of healthcare providers' perspective of cross-border healthcare utilization is quite important in border management initiatives. They wrote,

> Knowing healthcare providers' opinions regarding the cross-border use of healthcare services is important because of their capacity to influence patients' satisfaction and patients' demand for health services [and] physicians tend to have strong influence on health policy formation and implementation [4].

Our hypothesis is that recognizing and utilizing healthcare providers' opinions on cross-border healthcare service utilization would foster the development of effective healthcare policies, designing effective healthcare protocols and implementing joint cross-borders health interventions with quality assurance to the satisfaction of both the healthcare providers and the consumers. In turn, this approach would contribute to developing an efficiently functioning healthcare delivery system in border regions, a key step towards improved border landers' livelihoods; border peace and security and a united and integrated Africa.

We use a case of healthcare providers in the Tanzania-Uganda borderlands to provide evidence on perceptions, attitudes and practices as well as examining opportunities and barriers healthcare providers face in the course of fulfilling their professional and social roles in the borderlands. Specifically, the paper provides information on healthcare providers' awareness of cross-border healthcare utilization behavior and practices; perceived reasons on why patients from neighboring countries visit their facilities and services sought; the nature and the effectiveness of the existing communication system (referral) between providers on both sides of the border; problems resulting from attending patients from neighboring nation(s) and healthcare providers' recommendations on improving the situation. This paper presents findings from a bigger study conducted along the Tanzania-Uganda border to understand healthcare providers' perceptions of cross-border healthcare services utilization across the Tanzania-Uganda border.

Materials and Methods

Data for this paper are part of the bigger qualitative study we conducted in four Tanzania-Uganda border districts: Bukoba Rural, Bukoba Urban, Missenyi and Kyerwa, Kagera Region. We held 11 tape-recorded in-depth interviews (IIs) with ten healthcare providers from public health facilities (Two District Medical officers, four Medical Officer in-Charge, two Dispensary in-charge and two clinicians) and one healthcare providers at the private facility. The IIs guide questions included: What are the common health problems facing the border landers and for which ones do they seek healthcare across the border? What types of healthcare services they commonly seek? What are the perceived reasons for this behavior and its seasonality? What challenges do healthcare providers face in the course of caring for patients from the neighboring country and strategies used to solve them? And, what are your recommendations for improving cross-border healthcare services utilization across the border?

Following data collection, tapes on this issue were transcribed verbatim by the team members in each border district and IIs reports written on the same day of interviewing were submitted to the PI and Co-PIs (the team leaders in the four districts). In order to maintain quality and richness of content, we analyzed data in Kiswahili (the national language used during interviews) according to the guide questions [5] and English translation was then carried out. The aim was to understand healthcare providers' perceptions and practices in managing care for border crossers, as well as the challenges and barriers they faced. The Muhimbili University of Health and Allied Sciences Institutional Review Board reviewed and approved the research protocol (MUHAS IRB, Ref. No. 2017-09-29/EAC/Vol.XII/73). Permission to conduct the study was requested and granted by regional, district, division and ward authorities.

Results

Presence and Reasons for Cross-Border Healthcare Services Utilization Behaviors and Practices in the Study Area

We asked study participants whether cross-border healthcare services utilization was common in their areas. All interviewees reported border crossing for healthcare is practiced along and across the Tanzania-Uganda border. Border crossers seek biomedical, African therapy and spiritual healing. A health personnel interviewed in Bukoba, for example, noted, "Tanzanians cross the border to Mulago Hospital [Kampala, Uganda] seeking advanced healthcare while the Ugandans cross the border to Tanzania mainly for primary healthcare" [6]. A Medical Officer in-Charge in Kyerwa reported, "Lack of healthcare services at home and perceived quality primary healthcare services available in Tanzania, make Ugandans and Rwandese come to health facilities on this side of the border … The Tanzanians go to Mbarara and Kampala for advanced healthcare services unavailable at our facilities" [6]. Health personnel interviewed in Bukoba added,

> The government has increased healthcare budget tenfold … We are, therefore, currently providing quality primary healthcare services in the country compared to most of our neighbors … We run special groups-specific programs, the under fives, pregnant

> mothers and the elderly [60 years and above] … So, patients from neighboring countries Uganda, Rwanda and Burundi cross the border seeking primary healthcare services in Kagera Region [Tanzania] [6].

Similarly, study participants reported proximity to and familiarity with the health facility, social networks and economic and cultural capital additional pushing/pulling factors behind border crossing for healthcare along and across the Tanzania-Uganda border.

Specific Healthcare Services Sought

Study participants reported the majority of the border crossers seek antenatal care (ANC), delivery, reproductive and child health (RCH), counseling and testing (CTC), Tuberculosis (TB) testing and treatment and HIV and AIDS care and treatment. Other border crossers seek specific services – surgery, goiter treatment, fibroids diagnosis and treatment, gynecological and pediatric – from Missenyi District Designated Hospital, Mugana. The Tanzanians were reported visiting health facilities in Uganda for primary care (the borderlanders) and for advanced care (borderlanders and other Tanzania citizens). All the participants attested cross-border healthcare services utilization takes place all year round with more Ugandans and Rwandese pastoralists (the 'dry season birds'!) practicing transhumance coming into Kagera between May and mid-October.

Challenges Healthcare Providers Face in the Course of Caring for Patients from Neighboring Countries and Curbing Strategies in Place

We asked study participants "what challenges do you face when attending patients from neighboring countries?" Challenges reported included:

Difficulties Distinguishing Foreigners from Residents: the Medical Officer in-Charge, Mugana DDH, for example, reported there are several entry points from across the border into the catchment area: Kashenye, Minziro, Mutukula and Kakunyu and other numerous 'panya routes' or informal routes along the border. However, the Medical Officer in-Charge explained on means used to cross-check on patients' nationalities including, "Checking through RCH, ANC, TB, CTC and OPD registers [where faithful patients register their true foreign addresses]; patients having difficulties speaking Kiswahili but other first languages in Uganda; patients having escort cum translator; or when writing referral letters to their nearest health facilities" [6]. One Medical Officer in-Charge stated, "whenever necessary, we use health personnel sharing same backgrounds with border communities to distinguish Ugandans from Tanzanians [accent and some manners]" [6].

Language Barriers: some study participants reported non-fluency in Luganda and other first languages (Kinyankole, Kikiga, Kinyarwanda) spoken in the Tanzania-Uganda borderlands a barrier to communication with the crossers. In rare cases, Tanzanian low-cadre health personnel had difficulties communicating with crossers fluent in English or French. However, the providers reported the availability of healthcare providers fluent in first languages spoken in the borderlands and the crossers coming with escorts cum translators absorb shocks from this challenge.

In-House Challenges: the health personnel interviewed in Bukoba Municipal worried,

> If we get so many patients crossing the border … we may record disease [HIV, TB, Malaria] cases and vital events [births and deaths] not originating from Tanzania, resulting in high prevalence than reality … Public facilities depending sorely on government supplies [medicines and equipment] that match their catchment areas' monthly requirements may exhaust their stocks before the end of the month resulting in shortages that are not real … Unrealistic shortages would, in turn, hamper intended communities' rights to healthcare [6].

The Mugana DDH Medical Officer in-Charge reported increasing number of patients attended "would lead to heavy workload and or burn out among staff" [6]. Discussing frustrations Mugana staff face in the course of attending patients from across the border, the Medical Officer in-Charge stated, "Once we have referred patients to facilities in Uganda, we do not get feedback on their progress or adherence to the treatment … Yet, we cannot make follow up of patients we put on treatment" [6]. A Medical Officer in-Charge, Isingiro, reported experiencing overcrowding due to a number of Rwandese and Ugandans seeking healthcare during the dry season (May to mid-October). Adding, "[w]ith the expansion of this facility [Isingiro Health Center] introducing minor surgery services, better equipment and with adequate supplies, I hope the number of patients from neighboring countries will increase" [6]. Mugana DDH Medical Officer in-Charge added, "we refer patients put on HIV and AIDS or TB treatment to nearby facilities at home … However, we never receive any message from our counterparts when crossers revisit our facilities … At most, the pregnant mothers bring their ANC cards with them from facilities in Uganda" [6].

National Healthcare Laws and Policies, Professional Norms and Standards, Healthcare Provision Guidelines and Humanity Dilemmas: study participants reported on the dilemmas they face. They were aware it was illegal providing healthcare to non-citizens without prior (legal) arrangements within or between states. They knew through treating Ugandan or Rwandese patients, some of whom could be labeled 'illegal' or 'undocumented' migrants, they were committing legal offenses but fulfilling the right to healthcare principle. Private-for-profit health facility owners wondered why they could not provide healthcare services to whoever could pay, irrespective of nationality. Moreover, the providers were committed to medical profession norms and standards of providing quality and equitable healthcare services to all human-kind irrespective of

any background (sex, gender, nationality, race or social economic status). Healthcare providers at Missenyi DDH Mugana, a faith-based (FBO) and private-not-for-profit facility turned to the Catholic-dictated role of 'a good Samaritan' to justify why they provided healthcare services to everyone who met minimum requirements for treatment at that hospital. According to the Medical Officer in-Charge, individuals proven, beyond reasonable doubts, too poor to foot medical charges, receive medical costs wavers.

Healthcare Providers' Recommendations for Cross-Border Healthcare Services Utilization Enhancement

We sought study participants' recommendations on cross-border healthcare services utilization enrichment strategies. Proposed approaches included:

Improving Communication between Healthcare Providers on Both Sides of the Border: Mugana DDH Medical Officer in-Charge observed,

> Some patients from Uganda are referred to our facility by healthcare providers along the border on the Tanzania side or in Uganda … We also refer patients put on HIV and AIDS or TB care and treatment to client-identified nearby facilities in Uganda … However, we [healthcare providers] have no formal communication or referral systems in place, which makes follow up of patients difficult … Improving existing informal communication and referral initiatives would be a good start towards establishing health information management system in the borderlands [6].

Institute Health Information Management and Sharing System for the Borderlands and Adjoining Nation States: we asked study participants to comment on borderlanders' perception of Uganda as a source of human, animal and crop diseases that have affected or are threatening livelihoods on the Tanzania side of the border. All participants observed major diseases shaking the Great Lakes Zone are reported origination in Uganda. A Mugana DDH Medical Officer in-Charge, for example, explained,

> Many borderlanders consider HIV and AIDS to have originated in Uganda … Murbug virus was reported in that country since 2007 ... BXW [Banana Xanthomonas Wilt] and CWD [Coffee Wilt Diseases] have origins in Uganda ... Hence, instituting health information management system and sharing data on disease outbreaks management and control would facilitate clearing this fear ... Similarly, establishing disease control centers in the borderlands would facilitate creating a buffer zone preventing easy spread of diseases inland [6].

Establishing Experience Sharing Venues for Health Personnel in the Borderlands: Study participants had an opinion that sharing health management and control experience among healthcare practitioners in the Tanzania borderlands and between healthcare providers on the two sides of the border would benefit providers' understanding of each country's health system and policies. This understanding would facilitate reducing discrepancies in disease management and control procedures in the two countries thus minimizing fear of comprising quality of healthcare services provided to cross-border healthcare seekers.

Discussion

Findings from our study indicated cross-border healthcare services utilization behaviors and practices have been, and still are, going on along and beyond the Tanzania-Uganda border. Lack of service needed at home, socioeconomic and cultural capital and social networks are key push/pull factors behind this phenomenon. Healthcare practitioners face several challenges ranging from failure to distinguish crossers from the residents; in-house challenges including increased workload, fear of recording disease cases and vital events originating outside respective catchment areas; the inability to follow up TB and HIV positive patients enrolled on care and treatment plans and communication barriers among healthcare providers not fluent in any of the first languages spoken in the borderlands, which creates gaps between crossers' needs and providers' understanding. Similarly, healthcare providers face national healthcare laws and policies, professional norms and standards, healthcare provision guidelines and human dilemmas.

Healthcare practitioners have developed strategies to minimize shocks from these challenges. For example, whenever the need arises, they use fellow bilingual staff born in the borderlands or fluent in some first languages spoken to detect foreigners or serve as interpreters thus bridging crossers' needs and providers understanding. Healthcare providers turn to professional norms, the right to healthcare and ethics to justify why they treat patients from across the border. Similarly, providers at Mugana DDH, a FBO facility embrace the Catholic Church's 'Good Samaritan spirit' principle to validate provision of healthcare to everyone who visits the facility and meets set treatment guidelines. Following this principle, patients unable to afford medical costs receive treatment waivers.

However, healthcare practitioners in the study area did not demonstrate high levels of frustration as reported by Suphanchaimat, et al., (2015) among practitioners caring for migrants the world over. Language and cultural challenges, for instance, were reported critically impeding effective communication between migrants and providers, thus compromising the quality of care provided and triggering burn-out among providers. In our case study, the Tanzania-Uganda border crossers for healthcare share common characteristics with Kagera residents thus posing no serious cultural or linguistic challenges to providers.

Study participants' recommended strategies to improve cross-border

health services utilization need a discussion here. Participants reported there was no communication between healthcare providers on both sides of the border. Practitioners in Tanzania depended on information from border crossers on health services available at home to make referrals for patients diagnosed TB, HIV (or both) positive, put on treatment. With limited information, providers in Uganda or in the borderlands (Tanzania side) referred patients to Mugana Hospital. As a result, patients did not carry treatment records with them that could result to multiple or simultaneous treatments as observed by Homdes, et al., (2016),

> Lack of referral mechanisms could result in people using several healthcare providers for the same healthcare problem, which, in turn, could lead them to undergo the same diagnostic procedure more than once or even to engage simultaneously in several medical treatments, risking iatrogenic effect. The impact the duplicate use of health services has on the population's health and on the cost of healthcare cannot be ignored by policy makers. However, no referral system will be efficiently implemented without enlisting the collaboration of healthcare providers on both sides of the border [3].

Physicians in Mexico reported frustration from providing prenatal care to mothers but not delivering many of the babies as women prefer giving births in the US presumably expecting to claim U.S. citizenship for their children and eventually for themselves. In contrast, physicians in the U.S. reported taking high risks by attending deliveries with no prenatal care records [3]. As this study participants recommended, improving communication between healthcare providers on both sides of the border would guarantee quality services to crossers, raise satisfaction among the healthcare providers and healthcare seekers and reduce the duplicate use of healthcare services impact on the clients' health and healthcare expenditure. Initial steps would include establishing experience sharing venues like annual or biannual technical meetings, conferences and workshops for health personnel in the borderlands and instituting health information management and sharing system for the borderlands and adjoining nation states. State governments and the African Union Border Program (AUBP, 2007) could facilitate this transformation as part of soft border management for improved borderlanders' livelihoods, border peace, security and a united and integrated Africa.

Indeed, the importance of understanding healthcare providers' perceptions of cross-border healthcare services utilization cannot be overemphasized. Using U.S. and China examples, Homdes, et al., (2016) summarize providers' role in this regard as follows,

> Even [in China where] public health policy was taken away from physicians' hands, necessary technical consultation with medical professors made the removal of power from the Ministry of Health ineffective ... [In the present US], physicians control the Ministries of Health ... The top health officials, the Secretary of Health and Human Services, the Assistant Secretary of Health, the Surgeon General, and various agency heads of the U.S. Public Health Service are virtually all physicians. The power of the American Medical Association is legendary. And even when healthcare providers are not directly involved in policy making, they influence policy makers through personal links and common social class interest. Dentists do not enjoy as much power as physicians in policy definition; however, the number of U.S. residents who cross the border in search of dental care [in Mexico] is very important and, therefore, their impact on the [US-Mexico] border health sector network is far from negligible [3].

The situation is more-or-less similar in Tanzania where all posts in the health sector are manned by personnel with health and medical backgrounds except the Minister for Health, Permanent Secretary and Executive Director - TACAIDS positions that are presidential (political) posts. In their positions, healthcare professionals are capable of influencing policy makers through personal links and common social class interest through dialogue or strikes. The Medical Association of Tanzania (MAT) has been powerful and quite instrumental in negotiating with the government for improvements in health services in the country and doctors' remuneration.

According to Peter (2012) [7], during the 2012 nationwide strike (late January to February 10, 2012), for instance, MAT demanded doctors would not return to negotiation table until the Minister and Deputy Minister for Health and Social Welfare (MoHSW) alleged 'enemies of doctors and the health sector as a whole" [8] were sacked. Other MAT demands (as per Standing Orders that the government partially fulfilled) were accommodation or housing allowance of 30% of the doctors salaries; salary increase matching rising living costs; on-call allowance increased from TShs 10,000 ($4) to half per diem of respective region; health insurance to all health workers through the 'green card' cover of the National Health Insurance Fund (NHIF) and loans to acquire vehicles or transport allowance of 30% of their salaries. The doctors called off the strike after the Prime Minister suspended the Permanent Secretary and the Chief Medical Officer, MoHSW.

Kenya's doctors in public hospitals went on strike on Dec. 5 over pay and working conditions which lasted for 100 days (March, 2017) forcing the government to request for 500 Tanzanian doctors (and additional doctors from other African countries) to help the country deal with a shortage of doctors at its medical centers following a doctors' strike [9,10]. Speaking for the government, the Minister for Health said the ministry would release the doctors immediately as Tanzania had many graduate doctors yet to be employed or have just concluded their contracts but can still work [10]. However, MAT repudiated the plan saying Tanzania had a serious shortage of doctors. In addition, MAT demanded clarification on several

issues including why the decision was made in a hurry and in the run in general elections 2017? [11]. The Kenya Medical Practitioners, Pharmacist and Dentists Union (KMPDU) warned the government against hiring doctors from other countries but should settle Kenyan doctors' demands. KMPDU "directed its members to resume duty at the Kenyatta National Hospital (KNH) after the facility's management agreed to sign the Return to Work Formula (RTWF) [10]. KMPDU, Ministry of Health and Council of Governors who represented 47 counties signed the RTWF on March 14 ending the strike. According to the RTWF,

> Doctors [would] be entitled to a Doctors Allowance of KSh36,000 [$313]to KSh50,000 [$434] and a KSh20,000 [$173] risk allowance. The RTWF was also meant to pave way for a Collective Bargaining Agreement [CBA] to be signed and registered in court in the next 60 days. According to the CBA, the government [would] be employing at least 1,200 doctors for four years to bridge the current shortage [10].

Furthermore, healthcare providers have the capacity of influencing patients' satisfaction and patients' demand for health services at home (through the provision of quality and standard care) and abroad (through referrals and other networks). Hence, understanding and harnessing providers' perspectives of this phenomenon could inform and facilitate the planning and implementation of efficacious cross-border health policies and programs targeting the border regions and the borderlanders.

Prior to the 1990s scholars (historians, geographers, anthropologists and Lawyers) and policy makers recognized borders as separating and limiting entities, demarcating the beginning and the end of state sovereignty and sources of conflict; borderlands as poor, marginalized and neglected regions; state territories as human and capital sealed containers and borderlanders as subversive and passive subjects subjugated to governments' power abuse. Nation states central governments, therefore, put borders under tight surveillance: guard/military patrols, control towers, walls with barbed or electric wires, introducing exclusive citizenship (and citizenship rights) and migration laws and strict border crossing regulations. However, beginning in the 1960s, border regions (mainly in Europe and America) experienced rapid population growth and urbanization leading to complex forms of interconnectedness and interdependency among borderlanders of different demographic characteristics and backgrounds [12,13]. As such, different borders in different parts of the world have attained different levels of development explaining, in part, varied cross-border behaviors and practices they record including cross-border healthcare services utilization.

For example, cross-border medical access (from the US and Canada) brought tremendous growth in the healthcare sector in many Mexican border towns. According to Miller-Thayer (2010)'s study, Los Algodones, a small border town Christened by local U.S. newspapers "the Mecca of medicine,"

> [h]ad some 50 dentists' offices, 26 pharmacies, and 20 opticians' offices in a six-block radius from the border crossing in 2002 … [just a few years later] there were about 86 dentists' offices, 24 pharmacies, and 29 opticians' offices in the border zone, along with many physicians' offices, several barber/beauty shops, a health food store, restaurants, bars, souvenir shops and stalls, liquor stores, and a bakery. Furthermore, more offices were under construction [4].

Many African border regions are in remote locations with poor social and economic infrastructure. However, beginning in the 1990s, the majority of border points started urbanizing and there are signs of rapid development following support from the AUBP Unit (2007) of the African Union [14,15] and funders. We observed that main border crossing points along the Tanzania-Uganda border, Mutukula and Murongo, were somehow developed on the Ugandan side compared to the Tanzanian side and social activities taking place in these areas have increased since 2002. In Murongo, for example, the re-introduction of food crops market and construction going on the Ugandan side have brought life to this area. A tarred road to Mbarara has made transportation of passengers and commodities easy between the two countries. In Mutukula, the completion of the Bukoba-Kampala highway and the establishment of the one-border-stop-post (OBSP) have speeded up urbanization and its discontents including the mushrooming of (uncontrolled) business, squatters, entertainment, recreational venues and the emergence of new forms of prostitution observed in the town [16]. Several health facilities (drug outlets and private health facilities) were observed in Mutukula, Tanzania side. Kakunyu, Mutukula, Minziro, Kashenye and Katare facilities had undergone renovation and expansion; which would attract crossers seeking primary healthcare on the Tanzania side [5]. We hypothesize, with social and economic development in the borderlands, border crossing practices and behaviors, including cross-border healthcare utilization, will increase.

Findings from this study have policy implications too. The proposed harmonization of healthcare systems and protocols; improved referral mechanisms among providers across borders; harmonizing medical care costs and healthcare procedures; instituting central offices with interpreters and translators specialized in the medical field providing affordable services to health providers and crossers on either side of the border; harmonizing insurance policies and market or developing bi-national health programs will continue challenging traditional ways of thinking about public health and the notion of health systems contained within the nation-state. Cross-border healthcare utilization, therefore, will gain significant attention in high-level policy dialogues [1] within and among adjoining African nation states.

Conclusion and Recommendations

Healthcare practitioners in the Tanzania-Uganda borderlands have been

attending clients from across the border for a long time. Practitioners face several challenges including failure to identify clients from neighboring countries from citizens; language and cultural barriers; in-house problems like limited communication, increased workload, fear of recording disease cases and vital events not originating from their catchment areas indicating high prevalence that are not real and national healthcare laws and policies, professional norms and standards, humanity and healthcare provision guidelines dilemmas. Healthcare providers address these problems by using interpreters or bilingual healthcare providers and turning to professional ethics and facility philosophy to defend their behaviors and practices. Healthcare professionals have a strong influence on health policy formulation and implementation, which they could use to influence health systems and health policy changes favoring borderlanders' access to healthcare services available on both sides of the border.

This qualitative study has just scratched the surface of this public health and policy concern along the Tanzania-Uganda border and in the region. It is recommended conducting further multi-disciplinary research on both sides of the borders to increase our understanding of healthcare providers' and healthcare seekers' roles in the 'border control' to 'border management' transformation through the health sector. As Homedes, et al., (2016) have recommended, research could focus on healthcare providers' profiles, including socio-demographic variables and ability to communicate in first languages spoken in the borderlands; healthcare providers' practices' profile, including information about the number of patients attended, the percent of patients from the neighboring nation and the problems originated by them; the profile of patients crossing the border seeking healthcare, including socio-demographic variables, diagnoses and financing mechanisms; the referral mechanism between providers residing on opposite sides of the border; health providers' contributions to borderlanders' access to healthcare on either side of the border and the impact of healthcare providers' behaviors and practices on healthcare services quality and implications to nation states' health systems and health policy.

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