EAST AFRICAN COMMUNITY

EAC-SIDA INTEGRATED HEALTH PROGRAMME (ESIHP): 2016–2020

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Executive Summary

Introduction

The East African Community (EAC) is a regional inter-governmental organization comprised of the Republics of Burundi, Kenya, Rwanda, Uganda, and United Republic of Tanzania. It has an average population of 145.5 million people, land area of 1.82 million km square and combined GDP of $147.5 billion and GDP per Capita of $1014. The 17th Ordinary Summit of the Heads of State held in March 2016, admitted the Republic of South Sudan into the EAC. The Republic of South Sudan is expected to conclude the ratification process before the end of 2016.

The EAC was established under article 2 of the Treaty for the Establishment of the East African Community ("the Treaty") that entered into force in July 2000. The objectives of the EAC are to develop policies and programmes for widening and deepening co-operation among the Partner States in political, economic, social and cultural fields, research and technology, security, legal and judicial affairs for their mutual benefit. The EAC envisages accelerated, harmonious and balanced development and sustained expansion of economic activities. The treaty further provides for regional cooperation on health, cooperation for international partners and non-state actors, management of refugees and internally displaced populations, and gender empowerment and rights of the child among others.

The objectives of the EAC are pursued through various organs and institutions, which work on the basis of approved rules of procedure. The EAC consists of executive, legislative and judicial arms. The executive arm is composed of the Summit of the Heads of State and the Council, which are the policy-making organs of the community and the EAC Secretariat, the executive organ of the EAC. The decision making process in EAC is governed by the Protocol on Decision Making of 2001 which identifies consensus as the main approach to regional decisions and recommendations. Whereas the EAC Secretariat directly implements a limited set of interventions especially those focused on border areas, it is the responsibility of Partner States to implement the bulk of the interventions agreed upon in regional policy instruments as they are the ones that have the relevant agencies and requisite resources on the ground.

Situational Analysis and the Problem Statement

The EAC Partner States like other low income countries in Sub Saharan African experience a triple burden of disease namely backlog of common infections, under nutrition, and maternal mortality; increasing prevalence of non-communicable diseases (NCDs) and global health security threats such as pandemics and epidemics.

Indicators of Sexual Reproductive and other aspects of Maternal New-born Child and Adolescent Health and HIV&AIDS are particularly poor in the region: Only three Partner States (Rwanda, Tanzania and Uganda) achieved MDG 4 and only one achieved MDG 5 (Rwanda). Adult (15-49 years) HIV prevalence rates in the regions vary considerably with a low of 1.1% in Burundi to a high of 7.3% in Uganda (Kenya: 5.3%, Rwanda: 2.8%, Tanzania: 5.3%). EAC accounted for 9.9% of the world's 1.2 million AIDS-related deaths in 2014. The high burden of diseases puts enormous pressure on the already weak health systems and the meagre resources available for investments in the health sector. The pressure by the high burden of diseases is

further compounded by a skewed demographic profile characterised by very high annual population growth rates and the disproportionately high proportion of young people. Secondly, the fiscal space for investing in health in the region is narrow. Efforts to address the health systems challenges to SRHR and HIV/AIDS should concurrently address socio-economic and cultural determinants of health.

Introduction to the EAC Integrated Health Programme

The EAC Integrated Health Programme will build on actions, results and lessons of recent and current EAC Health Programmes particularly those focusing on regional cooperation on SRHR/RMNCAH and HIV&AIDS. Achievements of these initiatives included development of Policies, Strategies and Frameworks for regional cooperation on health. The HIV/AIDS programme among others spearheaded harmonized programming for mobile, vulnerable and key populations along the EAC transport corridors where health services are minimal and scattered. In response to the fragmented nature of health and HIV programming along the corridors the EAC Secretariat has developed key guidance documents to inform programming for the aforementioned populations. The EAC Open Health Initiative/RMNCAH successfully convened the 2nd East African Health Ministers and Parliamentarians Forum on Health and Symposium on Reproductive Maternal Newborn and Child Health and the Inter-parliamentary Forum on Population Health and Development whose outcome documents and recommendations informed the EAC agenda for women, children and adolescent health post 2015.

Goal, Objectives and Strategic Actions

The goal of the programme is to contribute towards elimination of preventable maternal, newborn and child deaths, AIDS and improvement of wellbeing among women, children, adolescents and families in the East African Community. The purpose is to strengthen regional cooperation in SRHR/RMNCAH and HIV/AIDS, adoption of innovative health policies and approaches while the objectives are to:

i. Harmonize and integrate SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines in the East African Community
ii. Strengthen SRHR/RMNCAH and HIV and AIDS Research, Innovations and Knowledge Management in the EAC
iii. Strengthen SRHR/RMNCAH and HIV and AIDS Leadership, Governance and Accountability in the EAC
iv. Strengthen the EAC Regional and National Health Systems towards universal coverage of SRHR/RMNCAH and HIV and AIDS services
v. Strengthen the capacity of EAC Secretariat and Partner States to coordinate and implement the project and related global and Africa regional Initiatives

Theory of Change

If EAC Partner States collectively and effectively harmonize SRHR/RMNCAH and HIV&AIDS service standards; strengthen research, innovations and knowledge management; enhance leadership, governance and accountability; implement actions towards universal health coverage; and strengthen regional coordination, then they are likely to attain benefits of stronger regional cooperation in health as envisaged in

article 118 of the EAC treaty and ultimately accelerate progress to towards elimination of preventable maternal, newborn and child deaths, AIDS and improvement of wellbeing among women, children, adolescents and families. The goal reflects the commitment of EAC Partner States to attain specific targets of the Sustainable Development Goal (SDG) 3 that relate to SRHR and HIV and AIDS.
The goal of the programme will be measured through a number of indicators including Maternal Mortality Ratio, Newborn Mortality Rate, Under-five Mortality Rate, Adolescent fertility rate, HIV incidence rate (paediatric and adult), HIV prevalence rate. Partner States shall generate data on these indicators as part of their national census and surveys and reported to the EAC.

The overall goal of the Programme will be achieved through a series of activities and processes linking the inputs to a hierarchy of outcomes. The Programme seeks to achieve stronger regional cooperation among Partner States in the areas of SRHR/RMNCAH and HIV/AIDS. This will be measured by indicators such as the number of regionally developed SRHR and HIV/AIDS health policies, laws, strategies, interventions and innovations adopted/being adopted by Partner States.

The following intermediate outcomes will contribute to the attainment of the aforementioned development objective/aim:

i. Harmonized and integrated EAC SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines developed
ii. Effective integrated EAC SRHR/RMNCAH and HIV and AIDS knowledge management platform
iii. Strengthening of SRHR/RMNCAH and HIV and AIDS leadership, governance and accountability effectively supported through regional actions
iv. Regionally developed interventions accelerate the attainment of objectives of Universal Health Coverage in EAC
v. Effective coordination of global and regional SRHR/RMNCAH and HIV/AIDS interventions in the EAC

Key Programme Actors: beneficiaries, roles of key stakeholders, governance and coordination

Relevant National Ministries and Agencies Responsible for Reproductive Maternal New-born Child and Adolescent Health/SRHR and HIV/AIDS, STI and Tuberculosis, Gender, Immigration, Refugees and Disaster Preparedness Programmes in the EAC Partner States are the primary beneficiaries of the EAC Integrated Health Programme.
Secondary beneficiaries of the Programme include CSOs with whom EAC works closely through identified networks such as the East African Health Platform (EAHP) and East African National AIDS Service Organisations (EANASO) as well as the private Sector while the ultimate beneficiary is the population of EAC. The following key stakeholders will be actively engaged in implementation of the EAC Integrated Health Programme.

i. Partner State's Ministries, responsible for EAC affairs, Health, Gender, women and community development; Finance and economic development, Departments and Agencies and National Parliaments and Senates;
ii. EAC Organs e.g. sectoral council of ministers of health and EAC Institutions
iii. Development Partners;
iv. Academic and research institutions;
v. Civil Society Organizations (CSO) and implementing partners;

vi. Private sector;
vii. Local communities.

Resource Needs

The EAC – SIDA Integrated Health programme 2016 – 2020 is estimated at USD $ 5,305,384 covering a period of four and a half years. A total of ten (10) staffing positions drawn from health, gender and community development and migration and refugee management have been identified to deliver on the results of this programme. Successful implementation of this programme will be based on effective resourcing in terms of financing and human resources, which will in turn impact on its sustainability. EAC will mobilise additional resources from partners and the Partner States to implement the programme fully.

Monitoring and Evaluation

The objective of the M&E is to generate evidence that will promote evidence-based decision making at all levels because it provides data/information that is essential for learning, prioritization and informed review of processes during implementation. It further provides a mechanism for assessing the extent to which allocated resources are used for the intended purpose effective implementation of the programme. Monitoring and evaluation will be based on the Monitoring and Evaluation Framework and the Monitoring and Evaluation Plan.

CHAPTER 1: INTRODUCTION

1.1 Background of the East African Community (EAC)

1.1.1 Introduction

The East African Community (EAC) is a regional inter-governmental organization comprised of the Republics of Burundi, Kenya, Rwanda, Uganda, and United Republic of Tanzania. It has an average population of 145.5 million people, land area of 1.82 million km square and combined GDP of $147.5 billion and GDP per Capita of $1014[1]. The 17th Ordinary Summit of the Heads of State held in March 2016, admitted the Republic of South Sudan into the EAC. The Republic of South Sudan is expected to conclude the ratification process and thereafter develop a detailed roadmap on the implementation of EAC projects and programmes.

[1] EAC Facts and Figures 2015

1.1.2 Legal basis for the EAC Integration

The legal basis for EAC integration covers its establishment, objectives, capacity, cooperation under health, refugees and gender, youth, women and children as well as collaboration with other organisations and institutions.

The EAC was established under article 2 of the Treaty for the Establishment of the East African Community ("the Treaty") that entered into force in July 2000.

The objectives of the EAC are to develop policies and programmes for widening and deepening co-operation among the Partner States in political, economic, social and cultural fields, research and technology, security, legal and judicial affairs for their mutual benefit; and to establish a Customs Union, a Common Market and subsequently, a Monetary Union; and, ultimately, a Political Federation in order to strengthen and regulate their relations, the benefits of which are to be shared equally[2]. The EAC envisages accelerated, harmonious and balanced development and sustained expansion of economic activities.

In accordance with article 4 of the Treaty, the EAC has capacity within each of the Partner States, of a body corporate with perpetual succession, and has power to acquire, hold, manage and dispose of land and other property, and to sue and be sued in its own name. In addition, it has power to perform any of the functions conferred upon it by the Treaty and to do all things that are necessary or desirable for the performance of those functions.

Article 118 of the Treaty provides for regional cooperation in health in various areas including, joint actions towards the control of communicable and non-communicable diseases and strengthening of sexual and reproductive health and rights and maternal child and adolescent health and HIV and AIDS, tuberculosis and Sexually Transmitted Infections (STIs).

In order to contribute towards the realization of the objectives of the EAC, the Partner States undertook to foster cooperation arrangements with other regional and international organizations whose objectives have a clear bearing on the objectives of the EAC[3]. Therefore, EAC collaborates with various regional and international bodies such as the African Union; the Common Market for Eastern and Southern Africa (COMESA); Southern African Development Community (SADC); Intergovernmental Authority on Development (IGAD); East Central and Southern Africa Health Community (ECSA); Bilateral and Multi-lateral Inter-governmental Collaboration with Governments e.g. Norway, USA, Germany, Sweden and European Union among others; Multi-lateral agencies such as World Bank, African Development Bank and GAVI; United Nations Agencies including the United Nations Children and Education Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), World Health

[2] Article 5 of the Treaty.
[3] Article 130(3) of the Treaty

Organization (WHO); Private Sector Institutions; Private Foundations and the Civil Society.

Under the area of cooperation in Peace and Security[4], there is a provision for development of common mechanisms for management of refugees in the region. However, matters of refugees and IDPs do not expressly provide for their human, health and related rights since refugees are mainly viewed as a security concern.

In EAC, it is recognized that women, play an important role in the economic, social and political development of the region[5]. This is premised on the fact that women are producers of goods and services, keepers of family health, first teachers of the children and guardians of morals and culture. Despite the cardinal role played by the women, they remain marginalized in the decision-making processes leading to limited access to education, health, income, information and communication technologies in comparison to their male counterparts.

1.1.3 The Fundamental Principles of the EAC

The fundamental principles that govern the achievement of the objectives of the Community include: mutual trust, political will and sovereign equality; peaceful co-existence and good neighbourliness and peaceful settlement of disputes, good governance, gender equality, recognition, promotion of human and peoples rights.

In addition, the Partner States are negotiating a protocol that addresses among others adherence to the principles of democracy, the rule of law, accountability, transparency, social justice, equal opportunities, gender equality, as well as the recognition, promotion and protection of human and peoples rights in accordance with the provisions of the African Charter on Human and Peoples' Rights.

1.1.4 EAC Organs and Institutions

The EAC consists of executive, legislative and judicial arms. The executive arm is composed of the Summit and the Council which are the policy making organs of the community. The Secretariat is the executive organ whose functions include strategic planning, management and monitoring programmes, coordination and harmonization of policies and strategies for the development of the community..

The East African Legislative Assembly (EALA) is the legislative organ of the Community established under Article 49 of the Treaty. Its core functions are legislative, oversight and representation. The membership of the Assembly consists of 45 elected members, nine from each Partner State, plus seven ex-officio members.

The East African Court of Justice (EACJ) is the judicial arm of the Community. It has jurisdiction over the interpretation and application of the Treaty, adjudicating disputes

[4] Article 124 (4) (5) (h) of the Treaty.
[5] Articles 121 to 122 of the Treaty

between the Community and its employees and requests for advisory opinions submitted by the Summit, the Council or a Partner State.

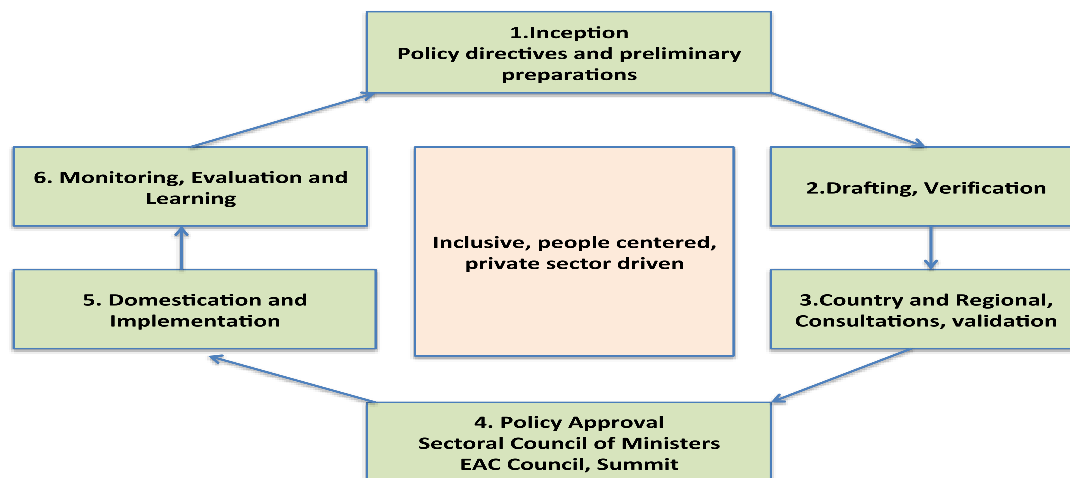
The EAC has established specialized institutions under Article 9(2) of the Treaty to support realization of the objectives of the community and they include the;

- East African Health Research Commission (EAHRC)
- Lake Victoria Basic Commission (LVBC).
- Inter-University Council for East Africa (IUCEA)
- Lake Victoria Fisheries Organization (LVFO)
- East African Development Bank (EADB)
- Civil Aviation Safety and Security Oversight Agency (CASSOA)
- East African Kiswahili Commission (EAKC)
- East African Science and Technology Commission (EASTECO)

1.1.5 How EAC works to deliver its objectives and programmes

The decision making process in EAC is governed by the Protocol on Decision Making of 2001. The protocol provides for procedure for decision making by the Council of Ministers which are made by consensus[6]. The EAC Secretariat coordinates development and harmonization of policies strategies and guidelines following the generic cycle indicated in Figure 1 below.

Fig: EAC Policy Formulation and Implementation Cycle



Notes:

[6] Article 2 of the Protocol on Decision making by the Council.

1. *Partner States through relevant ministries, agencies and stakeholder formations identify and prioritize development problems and solutions and subsequently direct the secretariat to address the issues raised*
2. *Responsive regional policies, strategies, programmes and guidelines among others are then developed*
3. *The draft policies, strategies, programmes and guidelines are then subjected to wide stakeholder consultations including both states and non state actors through country workshops/meetings*
4. *The draft policies, strategies, programmes and guidelines are then improved based on inputs from all Partner States and subsequently subjected to a regional validation exercise.*
5. *The validated policies, strategies, programmes and guidelines are then approved by the relevant policy organs (Sectoral Council, Council of Ministers and Summit of the Heads of State)***.** *Once approved, Partner States are directed to domesticate and implement the approved regional instruments – EAC Secretariat is also directed to implement interventions that can best be coordinated at the regional level.*
6. *Monitoring, Evaluation and Learning.*

1.2 Situational Analysis

This section highlights the socio-economic and demographic indicators; status of SRHR/RMNCAH, HIV/AIDS, TB and STIs, Refugees/IDPs, gender and rights of children and other vulnerable groups and Health Systems considerations in the EAC.

1.2.1 EAC Socio-economic and demographic indicators

Despite posting relatively high levels of economic development as demonstrated by year on year economic growth rates of about 5%, the share of the EAC's population below the poverty line is 38% while the share of government budget devoted to health in the region is 9%[7]. **Tables 1 and 2** below shows selected socio-economic and demographic indicators in the EAC, respectively.

Table 1: Selected socio-economic indicators in the EAC[8,9,10]

Indicator	Burundi	Kenya	Rwanda	Tanzania	Uganda
Life Expectancy at Birth (both sexes)	56	61	65	63	59
Percentage of the population living below the national poverty line	66.9	45.9	44.9	28.2	24.5
Adult Literacy Rate	67	87	71	73	73

[7] EAC.2014. Situational Analysis and Feasibility Study of Options for Harmonization of Social Health Protection Systems Towards Universal Health Coverage in the East African Community Partner States
[8] WHO 2013. Life expectancy data by country. http://apps.who.int/gho/data/node.main.688
[9] Human Development Report 2014 Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience
[10] Adult literacy rate.https://data.un.org/Data.aspx?d=SOWC&f=inID%3A74

Net Primary School Enrolment Ratio	95.4	95.9	96.6	89.7	96
Net Secondary School Enrolment Ratio	21	39.5	36.4	28.8	26
% Population with access to safe drinking water from improved sources	75	62	71	53	75

Mid-year population in the EAC increased by 2.9% from 139.4 million persons in 2012 to 143.5 million persons in 2014[11]. 64.2% of this population is aged 0-24 years, with Uganda having the highest percentage (70.4%) and Rwanda having the lowest (61%). Life expectancy in 2013 ranged between 50 and 65 years with Rwanda having the highest life expectancy at 64.5 years while Uganda the lowest at 50 years. According to the world population report (UNFPA 2014), the average annual population growth rate is high ranges from 2.7% per annum in Kenya and Rwanda to 3.1% per annum in Uganda.

Table 2: Selected demographic indicators in the EAC[12,13]

Indicator	Burundi	Kenya	Rwanda	Tanzania	Uganda
Total Population	10,395, 951	46,339,000	11,400,000	44,900,000	35,756,800
Annual population growth rate (%)	2.42	2.3209	1.8	2.7	3
Population of children aged 0-59 months (under five years)	1,840,083	6,812,000	1,587,000	7,273,832.0	6,685,900
Population of women of reproductive age (15-49 years)	2,439,221	11,405,000	2,845,000	10,905,117	8,042,600
Proportion of the population that is 15 years of age and below/%	45	42	43		45
Population of adolescents (10-19 years of age)	2,324,751	10,534,963	1,405,000	10,401,423	9,031,300

1.2.2 Status of SRHR/RMNCAH in the EAC

The status of women's, children's and adolescent's health is greatly influenced by the broader socio-economic environmental conditions and the ability of the health systems, policies and investments to deliver quality, equitable and accessible interventions to meet the needs of communities and individuals.

World over, forty-five (45) percent and 66% of maternal deaths occur within the first 24 hours and the first week respectively while 50% and 75% of all newborn deaths occur within the first 24 hours and first week of delivery respectively[14,15].

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[11] EAC Facts and Figures 2014

[12] UN.2015. World Population Estimates Using low fertility estimates.fertility/http://esa.un.org/wpp/fertility_figures/interactive-figures_TF-trajectories.htm/triangulated with actual Country Census Reports

[13] World Bank. Population ages 0-14 (% of total). http://data.worldbank.org/indicator/SP.POP.0014.TO.ZS

Globally, the number of women dying due to complications during pregnancy and childbirth decreased by 45% from an estimated 523,000 in 1990 to 289,000 in 2013[16]. Between 1990 and 2000, the annual rate of decline in maternal mortality was only 1.4% per year but increased to 3.5% per year during the period 2000 to 2013. Under-five mortality decreased by 49%, from an estimated global rate of 90 deaths per 1,000 live births in 1990 to 46 deaths per 1,000 live births in 2013[17]. The average annual rate of reduction in under-five mortality accelerated from 1.2% a year over the period 1990–1995 to 4.0% for 2005–2013.

In the sub-Saharan Africa, maternal mortality ratio (MMR) dropped by 41 per cent during the period 1990 and 2010 but the region still accounts for 56 per cent of global maternal deaths. The risk of a child dying before completing five years of age is still highest in the WHO African Region (90 per 1000 live births) - 7 times higher than that in the WHO European Region (12 per 1000 live births).

The main causes of maternal mortality are haemorrhage, high blood pressure, infections, unsafe abortions and obstructed labour while eighty three (83) % of the under-five deaths are caused by infections (pneumonia, diarrhoea, malaria, HIV/AIDS), neonatal complications or nutritional conditions[18]. Neonatal deaths account for about 44% of all under-five deaths.

The Global Investment Framework for Women's and Children's Health estimates that increasing health expenditure by just US$ 5 per person per year up to 2035 in 74 high-burden countries (inclusive of all the 5 EAC Partner States) could yield up to 9 times that value in economic and social benefits in terms of greater gross domestic product (GDP) growth through improved productivity, prevention of the deaths of 147 million children, 32 million stillbirths, and 5 million women by 2035[19].

During the period 1990 and 2013, maternal mortality ratio reduced by 76% in Rwanda, 55% in the United Republic of Tanzania, 53% in Uganda, 41% in Burundi and 17% in Kenya compared to by 45% globally[20]. The absolute maternal mortality ratio ranges from 210/100,000 live births (LBs) in Rwanda to 360/100,000 in Kenya, 360/100,000 in Uganda; 410/100,000 in the United Republic of Tanzania; and 500/100,000 in Burundi.

On the other hand, the annual rate of reduction in under-five mortality in the United Republic of Tanzania and Rwanda were 5.1% and 4.6 per annum respectively during

[14] WHO. 2012. Newborns: reducing mortality. http://www.who.int/mediacentre/factsheets/fs333/en/

[15] Nawal M Nour. 2008. An Introduction to Maternal Mortality. Rev Obstet Gynecol. 2008 Spring; 1(2): 77–81.

[16] http://www.who.int/gho/maternal_health/mortality/maternal_mortality_text/en/

[17] http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/

[18] http://www.who.int/gho/child_health/mortality/causes/en/

[19] Karin Stenberg, Henrik Axelson, Peter Sheehan, Ian Anderson, A Metin Gülmezoglu et al. 2013. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. www.thelancet.com Published online November 19, 2013 http://dx.doi.org/10.1016/S0140-6736(13)62231-X

20 Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division

the period 1990 and 2013, well above the required average rate of 4.4% per annum[21].

Efforts to improve maternal and child health is complicated by poor nutritional status inform of chronic malnutrition and severe acute malnutrition. The rate of stunting among under-fives ranges from 26% in Kenya to 58% in Burundi. The EAC has one of the highest fertility rates in the world. The total fertility rate In the Burundi, United Republic of Tanzania and Uganda is above 5 children per woman. The contraceptive prevalence rates have steadily increased over the years although they are still lower than the global and national targets. Unmet need for Family Planning in the region averages between 50-60%.

The Adolescent birth rate in the region is relatively high, with Uganda and United Republic of Tanzania posting rates of 134 and 116 births per 1,000 women aged 15-19 years respectively. Although the coverage for first Antenatal care visit is almost universal in all Partner States, half of the pregnant mothers do not benefit from the full range of prenatal services since only half of these make at least four visits. Facility deliveries range from 50% in Tanzania to 91% in Rwanda. Selected RMNCAH indicators are summarised in **Table 3** below.

Table 3: Selected RMNCAH indicators[22,23]

Indicator	Burundi	Kenya	Rwanda	Uganda	Tanzania
Maternal Mortality Ratio	500	488	*210*	438	432
Under five mortality rate	96	52	*50*	90	81
Neonatal mortality rate	36	22	*20*	27	21
Prevalence of Stunting in Children Under 5 years	58	26	*38*	33	42
Contraceptive Prevalence Rate	22	58	*53*	30	34
Adolescent fertility rate (births per 1,000 women ages 15-19)	29.6	92.5	32.3	134	116
Total Fertility Rate	6	3.9	4.2	6.2	5.4
Proportion of Pregnant Women Making 4 ANC Visits	29.8	57.6	*44*	48	42.7
Facility Delivery Rate	76.4	61.2	*91*	57.4	50.2
Proportion of mothers and newborns that have received Postnatal Care attendance within 48 hours of delivery	30	50.6	*42*	33	31
Percentage of children **aged 12-23 months** who are fully immunized-using **DPT3 and Pent3 as a proxy**	99	90	*92.6*	71.5	75.2
Percentage of HIV positive pregnant women attending Antenatal Care who have	72.9	76	*87*	71	83.3

21 UN Inter-agency Group for Child Mortality Estimation (IGME) 2013

22 Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division

23 Latest Demographic and Health Surveys of the Respective Partner States

received efficacious ARVs					

1.3 Status of HIV&AIDS, TB and STIs in the EAC

1.3.1 HIV and AIDS

UNAIDS estimated that in 2012 there were five million (4.6 - 5.3 million) people living with HIV in the EAC region. Kenya, Uganda and Tanzania each contributed a third of the people living with HIV (PLHIV) in the region. The estimated prevalence of HIV among adults 15-49 years of age in 2012 was 1.3% in Burundi, 6.1% in Kenya, 2.9% in Rwanda, 7.2% in Uganda and 5.1% in Tanzania, according to UNAIDS. From 1990 to 2012, the trend of HIV prevalence steadily declined in all countries but not Uganda, where the decline stagnates and slightly rises between 2005 and 2014[24].

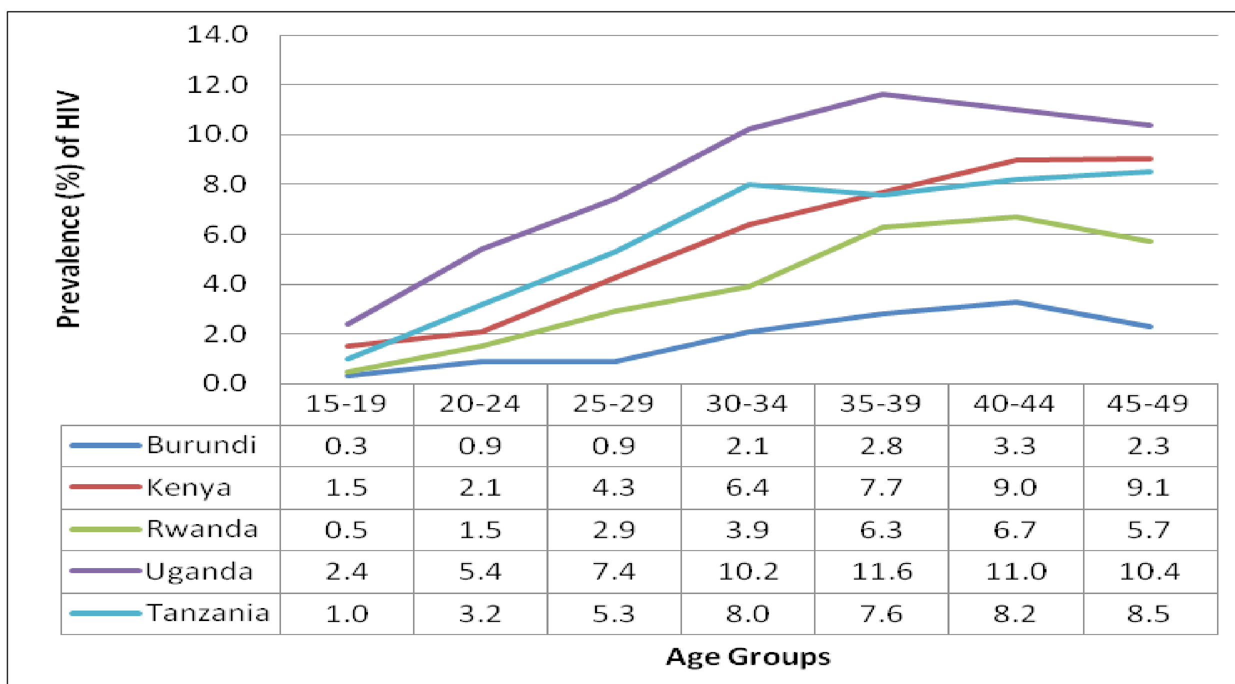
According to the UNAIDS 2014 report, the estimated prevalence of HIV among adults 15-49 years of age in the EAC region was 1.3% for Burundi, 6.1% for Kenya, 3.0% for Rwanda, 7.3% for Uganda and 5% for Tanzania. In general, with the exception of Uganda where there has been an increase from 6.2% in 2005, there has been a significant decline from 2.1% for Burundi in 2005, 6.6% for Kenya in 2005, 3.3% for Rwanda in 2005 and 6.6% for Tanzania in 2005 due to adoption of HIV combination preventions strategies. This overall downward trend in the prevalence of the HIV needs to be accelerated in the coming years and during the implementation period. The wide variation in prevalence between 1% and 7% across the Partner States requires concerted effort for reducing it in order to ensure that limited transmission occurs in the region.

In the region, the prevalence of HIV is disproportionately higher among women than men in all the five Partner States. Younger women 15 – 24 are more affected and are contributing to more to the observed new trends. This is due to many factors linked to gender inequality, lack of equity and poor access to information influencing access to key services.

Figure 2 below shows the trends in HIV prevalence for the general population by age group. It indicates that HIV prevalence is more concentrated in the age groups 30 to 44. This age group in general is economically and sexually active, has families and responsibilities and hence those living with HIV need to be protected to live longer productive lives.

Figure 2: Prevalence of HIV by Age

24 UNAIDS GAP report 2014



Source: UNAIDS Report on the Global AIDS Epidemic - 2013

Table 4 below shows that in 2012 there were 333,400 new infections in the region, with the majority being found in Kenya, Tanzania and Uganda. In general, about 4.9 million people were living with HIV out of which nearly 2 million were eligible for ART although only 75% of these were receiving treatment. With the release of the new WHO 2015 guidelines for initiating antiretroviral treatment, the number of patients who qualify for treatment will increase tremendously. There has been a consistent decline in the number of AIDS related deaths in all the countries in the East African Community since 2005, when ART became more widely available (Figure 3). Between 2001 and 2012, a total of 3.6 million people were estimated to have died from AIDS with the majority being in Tanzania (35%), Kenya (33%) and Uganda (24%). The remaining eight percent were in Burundi and Rwanda[25]. The significant decline in the number of AIDS related deaths is due to the massive increase in the scale-up of ART availability, access and uptake since 2005.

It has also been noted that HIV prevalence among sex workers, men having sex with men (MSM) and people who use drugs and other key and vulnerable groups[26]in most of the EAC Partner States is much higher

[25] Ferguson A and Kriitmaa K (2007). Hotspot Mapping along the Kampala-Juba Transport Route. IOM. April Nairobi
[26] Key and vulnerable populations in this region to include: Young women between the ages of 15 and 24 years; People living or working along national roads and highways; People living in informal settlements in urban areas; Migrant populations, Uniformed services men; fishing communities; Young people who are not attending school and those in school; Elderly persons; People with disabilities; Men who have sex with men (MSM); Sex workers and their clients; People who use illegal substances, especially those who People Who Inject Drugs (PWID); and Transgender persons, and Orphans and other vulnerable children and youth.

than the general population. Rwanda and Burundi have incomplete data given their categorization as low burden countries.

Table 7: Selected Key Features of HIV epidemic in EAC Partner States, 2012

Partner States	Number of New Infection (%)	Number of PLHIV (%)	Number of Adults Eligible or ART	Adults on ART (%)	Deaths (%)
Burundi	4,600 (1.4)	89,000 (1.8)	40,000	67	4,800 (2.3)
Kenya	98,000	1,600,000	680,000	81	57,000
	(29.4)	(32.7)			(27.1)
Rwanda	7,800 (2.3)	210,000	110,000	97	5,600 (2.7)
		(4.3)			
Tanzania	83,000	1,500,000	580,000	68	80,000
	(24.9)	(30.6)			(38.0)
Uganda	140,000	1,500,000	580,000	70	63,000
	(42.0)	(30.6)			(29.9)
TOTAL	333,400	4,899,000	1,990,000	77 2	210,400

Source: UNAIDS Report on the Global AIDS Epidemic - 2013

1.3.2 Sexually Transmitted Infections (STI)

Other STIs constitute a significant public health problem in the EAC region. A relatively higher percentage of women have STI/genital discharge/sore or ulcer than men. There is no consistent data on prevalence of STI among the key populations in various countries. Although self-reporting is not reliable enough, available data from two surveys conducted by IOM in 2005[27] and 2007[28] indicated that the prevalence of STIs among truck drivers and their assistants in Kenya and Uganda was 15% for those on the Northern transport corridor but extremely high at 68% for truckers plying the Kampala-Juba transport route.

[27] Morris C N & Ferguson A (2005). Hot-spot mapping of the Northern Corridor Transport Route: Mombasa-Kampala. International Organization for Migration. Nairobi
28 Ferguson A and Kriitmaa K (2007). Hot-spot mapping along the Kampala-Juba Transport Route. International Organization for Migration. Kampala

1.3.3 Tuberculosis

Globally, there are 22 high-burden countries that account for approximately 80% of all new TB cases arising each year; out of these, nine are in Sub-Saharan Africa including Kenya, Uganda and Tanzania whose burden of TB is shown in **Table 5** below. The TB epidemic in the EAC region is driven by the high prevalence of HIV. People infected with HIV infection have a ten times increased risk of developing TB compared to those not infected with HIV.

Table 5: Estimated burden of disease caused by TB (Number in Thousands)

Country	Mortality			Prevalence			Incidence			HIV+ve Incident TB Cases		
	2012	2014	Change	2012	2014	Change	2012	2014		2012	2014	Change
Kenya	9.2	9.1	-0.1	120	130	10	120	120	0	47	48	1
Uganda	5	4.1	-0.9	63	58	-5	67	62	-5	35	32	-3
Tanzania	6.4	6	-0.4	82	85	3	78	81	3	30	30	0

Source: WHO (2012) & WHO (2014).

Many TB patients are also infected with HIV. In the EAC region, at least one in five TB patients is HIV positive. However, in Burundi, Uganda and Tanzania, less than 50% of the HIV positive TB patients have been started on ART.

1.4 Status of Refugees/IDPs, Gender and rights of children and other vulnerable groups in the EAC

1.4.1 Refugees/IDPs

In the EAC context, there are thousands of civilians considered as refugees or asylum seekers who have fled conflicts such as civil wars and insecurity within the community and its neighbourhood. According to the UN refugees agency[29], by the end of 2015, the Partner States were hosting refugees from neighbouring countries as follows; Burundi (54,126); Kenya (552,272); Uganda (428,397); Tanzania (270,780; Rwanda (132,720). By April, 2016, 250,473 Burundians had been registered as refugees in Democratic Republic of the Congo (21,186); Rwanda (73,926); Tanzania (131,834); Uganda (22,330); and Zambia (1,197).

Human migration particularly Refugees and Internally Displaced People (IDPs) is one of the most neglected areas on the global health agenda[30]. Overall, refugees and IDPs involve millions of people that are in most cases vulnerable to many health challenges including HIV and AIDS due to the conditions that are present, during and after migration has occurred. Refugees and IDPs are in most cases vulnerable to the effects

[29] United Nations High Commissioner for Refugees: the UN Refugee Agency, Country 2015 operations profile.

[30] International Organization for Migration (IOM), 2012 Annual review report

of HIV and AIDs in view of the changed economic and social life, congested accommodation, social exclusion, loss of economic status, poverty, exploitation by those in authorities.

In July 2015, some Partners State witnessed large influx of asylum seekers/ refugees from the republic of Burundi. The EAC Secretariat mobilized resources and invoked article 118(a) and participated in joint action programme towards the prevention and control of the diseases affecting refugees then estimated at 75,768 in Kigoma, United Republic of Tanzania and the eastern province of 30,217 in Rwanda respectively. The absence of clear policy and strategic framework to address the refugees' management has negatively impacted the ability of EAC to sustainably respond to needs of refugees and IDPs.

1.4.2 Gender and Children Rights

Gender, is one of the 'structural drivers' producing the unequal living conditions out of which grow inequalities in health[31]. Gender is a risk factor to both SRHR and HIV and AIDS complications[32] and hence efforts to improve SRHR and HIV and AIDS will consider the gender dimensions which are to a large extent social constructs that influence power relations which in turn is reflected in form of difference in health, literacy, poverty, housing and living conditions. The impact of gender dimensions is particularly pronounced among the adolescents and young people. Gender based violence is fuelled by gender related risks that directly impact on SRHR and HIV&AIDS.

The EAC developed a draft regional strategy on promoting women in socio-economic development and women in business as well as a draft regional financial facility targeting women-owned businesses. The EAC Gender and Community Development Strategic Plan and the 4th EAC Development Strategy (2011-2016) provide guidelines for mainstreaming gender in EAC policies and programmes. However, the areas of SHRH and HIV and AIDS have not featured prominently.

Furthermore, the EAC recognizes that the greatest asset of its human resources is the youth. Therefore, mobilization and effective involvement of all men, women and youth for national development and social progress, should be a major instrument of development. In this direction, the Community developed the Youth Policy 2013 to address the youth challenges among others but the aspect SHRH and HIV and AIDs was not adequately addressed despite the youth being the major targets the intervention of SHRH and HIV and AIDs.

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31 Raewyn Connell (2012) Gender, health and theory: Conceptualizing the issue, in local and world perspective Social Science & Medicine 74 (2012) 1675e1683

32 Chineze J. Onyejekwe (2004) The Interrelationship Between Gender-based Violence and HIV/AIDS in South Africa. Journal of International Women's Studies. Volume 6 | Issue 1 Article 3

The Partner States have, in their individual capacities, signed and ratified a range of documents on children's rights, and adopted a variety of legislative, policy and programmatic measures to implement the resulting obligations. The Bujumbura declaration, 2012 demands that Partner States harmonise standards and approaches towards the protection and promotion of children rights in the EAC. The African Charter on the Rights and Welfare of the Child (ACRWC) and the UN Committee on the Rights of the Child (CRC) provides for a framework for the protection and promotion of children's rights. However, there is no clear provision in regard to protection of children rights in view of the SHRH and HIV and AIDs intervention.

1.5 Health Systems considerations

The WHO Framework for Health System Performance Assessment underpins the discussion on national RMNCAH policies, systems, and programmes[33]. The scope and breadth of interventions provided along the continuum of care provides a good basis for understanding the six key building blocks of the health system for systematic assessment, namely financing; health workforce; information; medical products, vaccines and technologies; service delivery; and leadership and governance.

1.5.1 Health Financing

Health financing[34] is still a challenge in the EAC region yet it drives universal health coverage agenda therefore improving health-financing is key to ensuring that all people can use promotive, preventive, curative, rehabilitative and palliative health services they need. The total health expenditure per capita in the EAC is USD 45 as opposed to UUSD 86 recommended to deliver an essential package of services within the context of Universal health Coverage (UHC)[35].

Although per capita total expenditure on health increased From 7 to 21 in Burundi, 19 to 45 in Kenya, 9 to 71 in Rwanda, 19 to 59 in Uganda and 10 to 49 in the United Republic of Tanzania between 2000 and 2013, much of this improvement has been outstripped by high population growth rates, high burden of communicable and non-communicable diseases and healthcare inflation as indicated in **Table 6** below.

Table 6: Overall status of health financing in the EAC Partner States in 2013

Indicator	Burundi	Kenya	Rwanda	Uganda	Tanzania
Per capita total expenditure on health at average exchange rate (US$)	27	66	71	59	49
General Government Expenditure on Health as a proportion of	14	6	22	9.6	11

[33] Christopher JL Murray Julio Frenk. 2006. http://www.who.int/healthinfo/paper06.pdf
[34] http://www.who.int/healthsystems/topics/financing/en/
[35] Report on Sustainable Financing Analysis for Universal health and HIV Coverage the EAC Region

General Government Expenditure (GGHE/GGE)					
Percentage of THE that is out-of-pocket payments	20	45	18	49	33
Percentage of population covered by health insurance	65	32	95	1	15

The proportion of EAC's population covered by any form of health insurance is 25% but varies from 1% in Uganda to 15% in Tanzania, 32% in Kenya, 65% in Burundi and 95% in Rwanda[36].

1.5.2 Human Resources for Health

In the EAC region, there is an acute shortage of Health workers, where none of the five countries has 23 health workers (doctors, nurses, midwives) per 10, 000 people - the minimum required to achieve an 80% coverage for deliveries by skilled birth attendants or measles immunization[37]. **Table 7** below shows the density of doctors, nurses and midwives per 10,000 populations

Table 5: Density of doctors, nurses and midwives per 10,000 populations[38]

Burundi	Kenya	Rwanda	Uganda	Tanzania	Required Standard
2	13	5	14	3	23

Coupled with the shortages are the other major challenges such as skill mix imbalance, mal-distribution, negative work environment, weak knowledge base[39] and low coverage of human resource planning and management tools and staff absenteeism (e.g. health worker absenteeism in Uganda is as high as 40-50% on any working day).

1.5.3 Availability of high quality Medicines and other health technologies:

The region is experiencing insufficient supply of high quality health commodities; inability to effectively regulate these quality commodities; and lack of access and awareness of how, why and when to use them, resulting in limited demand are key barriers preventing women and children from accessing and using appropriate commodities[40].

[36] EAC.2014.Situational Analysis and Feasibility Study of Options for Harmonization of Social Health Protection Systems Towards Universal Health Coverage in the East African Community Partner States.

37WHO. Strengthening health workforce to strengthen health systems. http://www.who.int/hrh/resources/strengthening_hw/en/

38 WHO. 2010. Achieving the health-related MDGs. It takes a workforce! http://www.who.int/hrh/workforce_mdgs/en/

[39] Lincoln Chen, Timothy Evans, Sudhir Anand, Jo Ivey Boufford, Hilary Brown (2010) Human resources for health: overcoming the crisis. Lancet 2004; 364: 1984–90

[40] UN Commission on Life-Saving Commodities for Women and Children, Commissioners Report September 2012

Stock out of critical health products including Antiretroviral drugs, condoms as well as medical devices such as ultrasound machines remain a challenge in the region. This could be as a result of poor investment in local manufacturing and many other factors. Partner States are collaboratively strengthening regulation, procurement and logistics management for medicines, vaccines and medical devices.

The EAC is supporting Partner States to introduce and scale up new vaccines such as pneumococcal vaccines and Rotavirus vaccine.

1.5.4 Health Information Systems

Whereas the capacity of health facilities to manage health information is progressively increasing, community health information systems (cHIS) are still not strongly incorporated as part of the National Health Information System. Apart from Burundi, the other 4 Partner States are using DHIS-2 as the backbone for the National Health Information Systems. DHIS-2 provides for generation of reports such as scorecards, geospatial information systems (e.g. G.I.S/GPS and remote sensing) and other advanced analytics that overlay health outcome data with key determinants such as infrastructure, availability of human resources and availability of medicines thereby enhancing decision-making, advocacy, oversight and accountability for results and resources. The existing information in the Partner States is poorly linked to each other and that at the EAC Secretariat. The emergence of m-health and e-health technologies provides an opportunity to strengthen information system at all levels including registration of vital statistics. This is an area that the EAC is willing to explore as a way of strengthening the health information systems for better programming.

1.5.5 Leadership and Governance

All Partner States have reproductive maternal newborn child and adolescent health, HIV and AIDS policies and strategic plans either as standalone documents or as part of the broader health policy/strategy. Despite the existence of these documents, newborn and adolescent health issues and management of STIs have not been effectively addressed at Partner State level.

Implementation of the various policy and Strategic Plan instruments is curtailed to varying degrees by inadequate or inflexible resources, weak oversight, inadequate accountability mechanisms and enforcement of regulations and standards.

1.5.6 Service Delivery

In all Partner States, the public and private sector each contribute about 50% towards health services and outcomes. Profound inequities continue to exist between the poor and rich, women and men, adolescents and adults and rural and urban populations. These inequities result from differences in exposure to various factors such as poor road infrastructure, lack of transport and insufficient supplies, human resources shortages and poor distribution, weak referral, supervision and management system,

poor coverage and outreach, lack of technical, quality, medicines/contraceptives supplies and equipment. The inequality may also be as a result of stigmatization, or gender based violence.

Health systems in the region are not well designed to respond to emergencies such as major displacements thereby leading to overreliance on international humanitarian agencies to respond to such emergencies.

Diverse and poorly integrated packages, standards and guidelines for RMNCAH (including immunization, nutrition, HIV/AIDS) exist in the region. The pace of development of urban health systems is outstripped by the rate of urbanization being experienced throughout the region. The existing healthcare infrastructure need to be upgraded in line with the needs of the growing population and to provide services in a manner that is appropriate and assures privacy and confidentiality.

1.6 Problem Statement

The EAC Partner States like other low income countries in Sub Saharan African experience a triple burden of disease namely backlog of common infections, under nutrition, and maternal mortality; increasing prevalence of non-communicable diseases (NCDs) and global health security threats such as pandemics and epidemics.

Indicators of Sexual Reproductive and other aspects of Maternal New-born Child and Adolescent Health and HIV&AIDS are particularly poor in the region: Only three Partner States (Rwanda, Tanzania and Uganda) achieved MDG 4[41] and only one achieved MDG 5 (Rwanda)[42]. Adult (15-49 years) HIV prevalence rates in the regions vary considerably with a low of 1.1% in Burundi to a high of 7.3% in Uganda (Kenya: 5.3%, Rwanda: 2.8%, Tanzania: 5.3%). EAC accounted for 9.9% of the world's 1.2 million AIDS-related deaths in 2014 while three EAC Partner States – Kenya, Uganda and Tanzania – feature among the 22 high-burden TB countries globally that account for approximately 80% of all new TB cases arising each year.

The high burden of diseases puts enormous pressure on the already weak health systems and the meagre resources available for investments in the health sector. The pressure by the high burden of diseases is further compounded by a skewed demographic profile characterised by very high annual population growth rates averaging 2.7% over the past decade[43] and the disproportionately high proportion of young people. Sixty four present (64%) of EAC's population of 145.5 million is aged 0-24 years. Secondly, the fiscal space for investing in health in the region is typically narrow. The region's combined Gross Domestic Product (GDP) of $147.5 billion and

[41]United Nations Children Fund. 2015. Levels and Trends in Child Mortality, 2015 Report of the UN Inter-agency Group for Child Mortality Estimation.

[42] National Institute of Statistics of Rwanda. 2015. Demographic and Health Survey [DHS] 2014/2015 Key findings;

[43] East African Community Secretariat: Facts and Figures, 2015

GDP per capita of $1,014.

The ability of the health systems in the region to effectively deliver health services is curtailed by the high burden of disease, the low economic base, demographic pressure, environment and socio-cultural challenges. The total per capita expenditure on health is only about USD 45 as opposed to the USD 86 required to deliver a package of services within the framework of the Universal Health Coverage agenda[44]. The report on sustainable financing of Universal Health and HIV coverage in the EAC also notes that severe inadequacy of human resources for health, medicines and related health products, infrastructure impacts negatively on the region's health systems. This is compounded by the high levels of inefficiencies in application of these key inputs/resources[45].

There is a paucity of integrated EAC regional SRHR/RMNCAH and HIV/AIDS service package, standards and guidelines, which in turn affects EAC's ability to promote integration of actions and maximization of best practices and innovations. The health sector has a myriad of knowledge management platforms, which are not integrated thereby reducing their synergistic benefits. Adoption of leadership, governance and accountability framework and tools varies among Partner States. There is need to harmonise these frameworks thereby benefiting from best practices and innovations in this area. All Partner States being Member States of the World Health Assembly have adopted the concept of Universal Health Coverage. There is need to health policy and systems reforms towards the attainment of the objectives of UHC.

Social, cultural and environmental factors significantly influence SRHR and HIV/AIDS outcomes. Pervasive social and cultural practices infringe on the rights of the people such as deprivation from access to essential health services of any cause as well as outright violence especially within the context of gender based violence (GBV) and violence against children (VAC) both of whose prevalence in the region is relatively high. Inadequate access to quality health promotional information especially among young people, illiterate communities and vulnerable populations negatively impacts on their ability to access health services.

In the EAC, there are incidences of refugees who flee their home countries due to insecurity and other factors. However, there is no regional refugee policy / strategy to address their health and other needs.

The current and projected future SRHR and HIV&AIDS are enormous and resource draining, the EAC Partner States seek to use the integrated health project to address the identified SRHR and HIV&AIDS through collectively collaboratively reviewing the

[44] EAC. Report on Sustainable Financing of Universal Health and HIV Coverage in the EAC

[45] WHO. 2010. World Health Report 2010. Health systems financing: the path to universal coverage

existing laws, policies, packages, standards and guidelines, strengthening of knowledge management; implementation of actions in support of the Universal Health Coverage agenda and strengthening leadership, governance and accountability and regional coordination.

1.7 Introduction to the EAC Integrated Health Programme (2016-2020)

1.7.1 Current EAC Health Programmes and Initiatives

The areas of regional cooperation on Health are coordinated through 5 specialized Units of the EAC Health Department namely Reproductive, Maternal, Child and Adolescent Health and Nutrition; Health Systems, Research and Policy; HIV & AIDS, Tuberculosis and STI; Medicines and Food Safety and Disease Prevention and Control. Whereas the Health Department coordinates health policy, systems and programmes issues, the East African Health Research Commission (EAHRC) coordinate health research issues.

Regional cooperation in Sexual Reproductive Health and Rights (SRHR) and Maternal New-born Child and Adolescent Health and HIV&AIDS, TB and STIs are stand-alone and weakly integrated projects. Projects under the RMNCAH unit namely the Open Health Initiative and the EAC-UNFPA SRHR project have raised regional attention of key EAC policy organs including the Summit of the Heads of State and Council of Ministers to women's, children's and adolescent's health issues; improved accountability for results as resources through a regional data warehouse and website and EAC Regional RMNCAH Scorecards; tracking of resources and facilitation of technical exchanges among Partner States. On the other hand, the EAC Regional HIV and HIV, TB and STIs Programme which has been implemented since 2008 has improved the legal, policy and programmatic environment for HIV and AIDS Programming through supporting development of the EAC HIV and AIDS prevention and management law 2012; comprehensive analysis of Gaps in HIV and AIDS laws, policies and strategies; development of the EAC Regional HIV and AIDS Response report 2013 and conduct of various researches.

1.7.2 Achievements

The various health programmes and projects have made major achievements including:

i. Initiated steps to facilitate sustainable financing in the region by undertaking a Sustainable Financing Analysis of Universal Health and HIV Coverage for the EAC region,. The analysis report outlines the financing options available for maximizing fiscal space in the Partner States The Study findings have been critical and the basis for an Issues Paper that will guide a High Level dialogue

on sustainable financing on Health and HIV and AIDS in the EAC region involving the Ministers of Health and Finance from the Partner States

ii. The enactment of the EAC HIV and AIDS Prevention and Management Act 2012

iii. Spearheaded harmonized programming for mobile, vulnerable and key populations along the EAC transport corridors where health services are minimal and scattered. In response to the fragmented nature of health and HIV programming along the corridors the EAC Secretariat has developed key guidance documents to inform programming for the aforementioned populations

iv. Developed the **EAC Regional RMNCAH Score Card** and National Scorecards used to monitor compliance and implementation of various EAC regional Health policies, laws and regulation by the EAC Partner States

v. Successfully convened the 2nd East African Health Ministers and Parliamentarians Forum on Health and Symposium on Reproductive Maternal Newborn and Child Health and the Inter-parliamentary Forum on Population Health and Development whose outcome documents and recommendations informed the EAC agenda for women, children and adolescent health post 2015

vi. Supported the tracking of RMNCAH resources the Republic of Rwanda, United Republic of Tanzania and Republic of Uganda thereby strengthening National Health Accounts (NHAs);

vii. Developed a regional RMNCAH a data warehouse that is connected to all Partner States' DHIS2 (http://hmis.eac.int/portal/) and website (http://ohi.eac.int/);

viii. Developed Compendia on EAC Medicines Regulatory Harmonization guidelines and requirements

ix. Conducted joint inspection of medical schools and other health institutions in the region as a way to improve quality of training and practice

x. Undertook a study on harmonization of Nurses and Midwives training curricula, focusing on procedures on regulation of admission criteria, training, certification, internship, registration and practice, inspection, accreditation and mutual recognition conducted and report validated by EAC Partner States' experts in November 2014. The recommendations of the study will be used by the Partner States to streamline the various components outlined above.

1.7.3 Lessons Learnt

The lessons learnt during the course of implementation of the EAC health projects and programmes are outlined below:

i. Strong partnerships and integrating of activities with other programmes have enhanced our speed of implementation of health interventions

especially in cross-cutting areas including financing, human resources for health, medicines and related technologies.

ii. Use of Expert Working Groups and small committees involving of experts form Partner States and consultants has been helpful in speedy decision making, creates ownership and speedy implementation and realisation of results.

iii. Lack of robust integrated knowledge management systems, including use of innovative analytics and mapping technologies, affects the ability of the EAC Secretariat and Partner States to effectively use evidence for policy and practice.

iv. Positioning of EACS Staff (Open Health Initiative Officers and National Medicines Regulatory Officers) at Partner State level has played a big role in effective and timely implementation of Council decisions at country level.

v. Consideration of key policy issues by high level policy makers (e.g. the EAC Inter-parliamentary Forum) during advocacy for a helps keep the agenda alive in regional discourse

vi. Regional policy making processes that meaningfully involve civil society and private sectors promotes broad-based buy-in and implementation by all stakeholders e.g. the active participation of the EAC Civil Society Forum in the development and enactment of the EAC HIV and AIDS Prevention and Management Act and the East African Health Platform in scaling up rights based approaches in maternal health.

1.8 The EAC -SIDA Integrated Health Programme (2016-2020)

The EAC-SIDA Integrated Health Programme (ESIHP) is part of the broader EAC Integrated Health Programme that is based on the EAC Integrated RMNCAH Policy Guidelines (2016-2030), RMNCAH Strategic Plan (2016-2021) and the EAC HIV and AIDS Strategic Plan (2015-2020). The EAC IHP is further based on relevant provisions national strategies, the EAC Health Sector Strategic Plan (2015-2020), the EAC gender and community development, labor and migration initiatives currently being undertaken by the EAC, as well as other global policies and strategies and particularly Sustainable Development Goals (SDGs). Whereas the EAC Integrated Health Programme is estimated to cost USD 10.3 million. The Government of Sweden through Sida has committed 5.3 million (37 Million Kroner) to support the ESIHP.

In order to optimally operationalize the EAC Integrated Health Programme the EAC Secretariat will mobilise additional development and implementing partners as well as Partner States to provide additional resources. The Programme is premised on the

need to improve efficiency in policy implementation through multi-disciplinary, health systems-wide and multi-sectoral actions in line with the multi-faceted determinants of health outcomes and the interrelated aspects of the Sustainable Development Goals.

1.9 Cross-cutting issues

1.9.1 Gender

The ESIHP will promote gender-sensitive policies that include both men and women's concerns in the EAC integration agenda. However, due to the disproportionate exclusion of women in decision-making as well as their relatively poor access to health services and information this project will pay greater attention to gender inequality and the factors that fuel it in the EAC region. This is particularly important because women are engaged in many socio-economic activities and other productive responsibilities and their involvement in the programme will be an important contribution to development.

1.9.2 Rights-based Approaches

The ESIHP will also promote and take cognisance of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments. The success of the integrated programme will to a large extent dependent on protecting and promoting the rights of those who are socially excluded, marginalised and vulnerable. The programme will promote policies and decisions that will facilitate human rights protection not only a priority to ensure the rights of people living with and at-risk for HIV, but to address public health goals as well. This is premised on the belief that for all EAC citizens, particularly the vulnerable and key populations cannot be reached unless the advancement of human rights is a primary component of this integrated health programme and related policy development, and ultimately, practice, and ensure access to health services and information for all without discrimination. As such one of the tenets of this programme will be promotion of legal reform and community empowerment and mobilisation to ensure the rights and health of all of EAC citizens.

CHAPTER 2: GOAL, OBJECTIVES AND STRATEGIC ACTIONS

2.1 Goal

Contribute towards elimination of preventable maternal, newborn and child deaths, AIDS and improvement of wellbeing among women, children, adolescents and families in the East African Community.

2.2 Purpose

The purpose of the ESIHP is to strengthen regional cooperation in SRHR/RMNCAH and HIV/AIDS, adoption of innovative health policies and approaches.

2.3 Objectives

The objectives are:

i. Harmonize and integrate SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines in the East African Community
ii. Strengthen SRHR/RMNCAH and HIV and AIDS Research, Innovations and Knowledge Management in the EAC
iii. Strengthen SRHR/RMNCAH and HIV and AIDS Leadership, Governance and Accountability in the EAC
iv. Strengthen the EAC Regional and National Health Systems towards universal coverage of SRHR/RMNCAH and HIV and AIDS services
v. Strengthen the capacity of EAC Secretariat and Partner States to coordinate and implement the project and related global and Africa regional Initiatives

2.3 Strategic Actions

Objective 1: Harmonize and integrate SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines in the East African Community

1.1. Develop harmonized integrated SRHR/RMNCAH and HIV&AIDS Packages, Standards and Guidelines
1.2. Develop the minimum package, Standards and Guidelines for HIV and AIDS, STI, TB in the EAC region

Objective 2: Strengthen SRHR/RMNCAH and HIV and AIDS research, innovations and knowledge management in the EAC

The strategic action under this objective is to upgrade the existing EAC HIV&AIDS Programme and the EAC OHI-RMNCAH Programme Knowledge Management Systems into an Integrated EAC Regional SRHR/RMNCAH, HIV&AIDS and Health Knowledge Management Platform.

Objective 3: Strengthen SRHR/RMNCAH and HIV and AIDS Leadership, Governance and Accountability in the EAC

The strategic action under this objective is to develop innovative Advocacy documents, tools and materials.

Objective 4: Strengthen the EAC Regional and National Health Systems towards universal coverage of SRHR/RMNCAH and HIV and AIDS services

The strategic action under this objective is to build the Capacity of the Partner States on Sustainable and Alternative financing of SRHR/RMNCAH, HIV and AIDS and Health.

Objective 5: Strengthen the capacity of the EAC Secretariat and Partner States to coordinate and implement the project and related global and Africa regional Initiatives

5.1. Develop the human resource and operational capacity of EAC Secretariat and Partner States to coordinate and implement the project
5.2. Provide Programme Coordination and Oversight Support

CHAPTER 3: THEORY OF CHANGE

3.1 Introduction

This section summarizes various aspects of the theory of change for the EAC-SIDA Integrated Health Programme (ESIHP). It provides a summary statement on the theory which links the intervention, changes processes and the ultimate goal; overall goal/desired change; hierarchy of outcomes, the change process and outcomes framework; inputs in terms activities; actors including beneficiaries and key stakeholders and risks and assumptions[46].

3.2 Summary Statement of the Change

If EAC Partner States collectively and effectively harmonize SRHR/RMNCAH and HIV&AIDS service standards; strengthen research, innovations and knowledge management; enhance leadership, governance and accountability; implement actions towards universal health coverage; and strengthen regional coordination, then they are likely to attain benefits of stronger regional cooperation in health as envisaged in article 118 of the EAC treaty and ultimately accelerate progress to towards elimination

46 Danielle Stein and Craig Valters. 2012. Theory Of Change In International Development

of preventable maternal, new-born and child deaths, AIDS and improvement of wellbeing among women, children, adolescents and families.

3.3 Overall goal and change markers

The overall goal of the ESIHP is to contribute towards elimination of preventable maternal, new-born and child deaths, AIDS and improvement of wellbeing among women, children, adolescents and families. The goal will be measured through a number of indicators including Maternal Mortality Ratio, New-born Mortality Rate, Under-five Mortality Rate, Adolescent fertility rate, HIV incidence rate (paediatric and adult), HIV prevalence rate. Partner States shall generate data on these indicators as part of their national census and surveys and reported to the EAC.

The overall goal reflects the commitment of Partner States to deliver on national, regional and global instruments such as the Global Strategy for Women Children and Adolescent Health 2016-2030[47], the global target for elimination of AIDS by 2030 and the Sustainable Development Goal (SDG) 3. which seeks to ensure healthy lives and promote wellbeing for all at all ages.

3.4 Description of the change process, hierarchy of outcomes and change markers

The overall goal of the Programme will be achieved through a series of activities and processes linking the inputs to a hierarchy of outcomes. As its development objective, the Programme seeks to achieve stronger regional cooperation among Partner States in the areas of SRHR/RMNCAH and HIV/AIDS. This will be measured by indicators such as the number of regionally developed SRHR and HIV/AIDS health policies, laws, strategies, interventions and innovations adopted/being adopted by Partner States.

The outcomes framework for the ESIHP is described in this section **(Figure 4)** shows the hypothetical cause-effect links between the various levels of outcomes and is based on the belief that the programme is able to directly influence the proposed changes and effective collaboration with the relevant sectors and institutions within the EAC Secretariat and Partner States as well as global and regional development partners.

The theory of change for this programme is not exhaustive since it has only prioritized a number of interventions and intermediate results while Partner States and other stakeholders are expected to implement a host of other contributory actions. The following intermediate outcomes will contribute to the attainment of the aforementioned development objective/aim:

vi. Harmonized and integrated EAC SRHR/RMNCAH and HIV/AIDS Service

[47] WHO. 2015. Global Strategy for Women Children and Adolescents Health 2016-2030.pdf

Packages, Standards and Guidelines developed

vii. Effective integrated EAC SRHR/RMNCAH and HIV and AIDS knowledge management platform
viii. Strengthening of SRHR/RMNCAH and HIV and AIDS leadership, governance and accountability effectively supported through regional actions
ix. Regionally developed interventions accelerate the attainment of objectives of Universal Health Coverage in EAC
x. Effective coordination of global and regional SRHR/RMNCAH and HIV/AIDS interventions in the EAC

Realization of these intermediate outcomes will contribute to the following result areas of the SIDA Strategy for SRHR in Sub Saharan Africa (2015-2019):

i. **Focusing on women's and children's health and SRHR:** a) increased access to integrated basic health services for women and children; b) Reduced number of unwanted pregnancies; c) improved access to safe and legal abortions and d) Fewer HIV-infected children
ii. **Focusing on the health and SRHR of young women and men:** a) Better conditions for young people to make informed decisions about their health, sexuality and reproduction; b) Reduced number of new HIV infections and c) Improved access to SRHR.
iii. **Focusing on strengthened health systems for greater access to SRHR:** a) Increased use of high-quality statistics and evidence-based information in health management; b) Strengthened conditions for transparency, participation and account-ability in health systems; c) Improved knowledge among decision-makers about more sustainable and equitable health systems
iv. **Strengthened democracy and gender equality, and greater respect for human rights:** a) Increased gender equality focusing on prevention of child marriages and sexual and gender-based violence, including female genital mutilation.

In addition, consideration will be given to mitigation of impact of human trafficking and interventions to address the health needs of key and vulnerable populations.

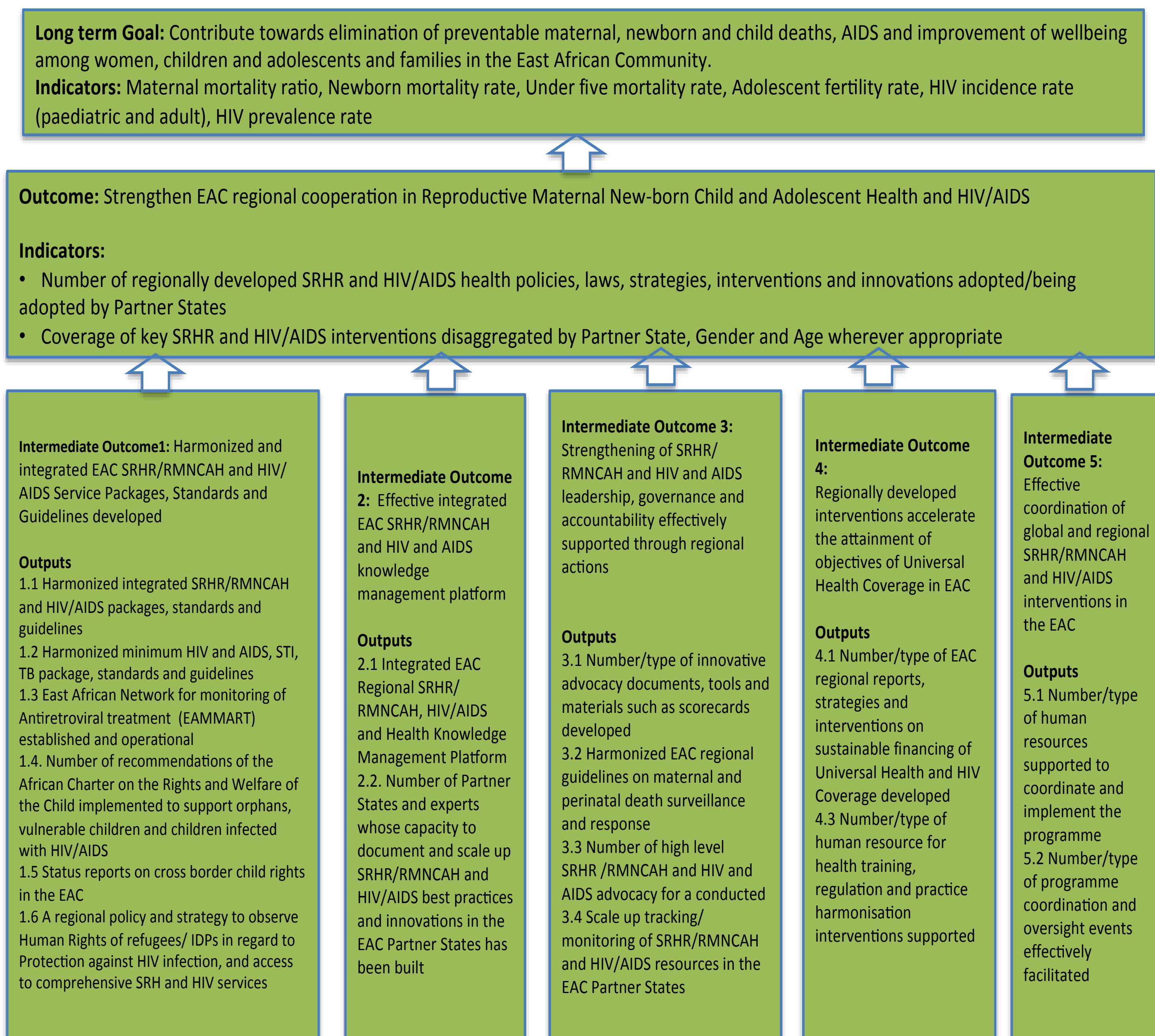
Development of SRHR and HIV/AIDS service packages, standards and guidelines that determine how countries invest in RMNCAH and HIV and AIDS will be backed by interventions that strengthen research and innovation; leadership governance and accountability; health systems strengthening interventions towards Universal Health Coverage; and coordination of regional efforts.

Although the EAC regional policies, strategies, guidelines and standards are expected to inform and improve relevant national documents and frameworks, the ultimate goal of eliminating preventable deaths and AIDS will take relatively long to achieve. The intermediate programme outcomes will in turn be pursued through a host of activities that will deliver outputs in **Table 8** below:

Table 8: Intermediate outcomes and outputs

Intermediate outcome	Outputs
1. Harmonized and integrated EAC SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines developed	1.1. Harmonized integrated SRHR/RMNCAH and HIV/AIDS packages, standards and guidelines 1.2. Harmonized minimum HIV and AIDS, STI, TB package, standards and guidelines
2. Effective integrated EAC SRHR/RMNCAH and HIV and AIDS knowledge management platform	2.1 Integrated EAC Regional SRHR/RMNCAH, HIV/AIDS and Health Knowledge Management Platform
3. Strengthening of SRHR/RMNCAH and HIV and AIDS leadership, governance and accountability effectively supported through regional actions	3.1 Number/type of innovative advocacy documents, tools and materials such as scorecards developed
4. Regionally developed interventions accelerate the attainment of objectives of Universal Health Coverage in EAC	4.1 Number/type of EAC regional reports, strategies and interventions on sustainable financing of Universal Health and HIV Coverage developed
5. Effective coordination of global and regional SRHR/RMNCAH and HIV/AIDS interventions in the EAC	5.1 Number/type of human resources supported to coordinate and implement the programme 5.2 Number/type of programme coordination and oversight events effectively facilitated

Figure 4: The Outcomes Framework



3.5 Activities

The change process is hinged on a set of activities described below that must be undertaken to deliver specific outputs under each of the intermediate outcomes.

Table 9: Activities

Intermediate outcome	Activities
1. Harmonized and integrated EAC SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines developed	The following activities will be conducted to deliver an integrated EAC integrated SRHR and HIV/AIDS service package, standards/guideline; baseline assessment of the relevant existing packages and guidelines; development of the draft documents with support of consultant (s) and regional meetings of experts from Partner States; country consultations and regional validation exercises. Similar activities will be conducted to also develop a minimum package, Standards and Guidelines for HIV and AIDS, STI, TB in the EAC region whose main output is a harmonized EAC regional algorithm for prevention, treatment and diagnosis of STIs. Efforts will be made to ensure that activities meant to deliver of these two sets of services packages; standards and guidelines are carried out in such as way as to maximize effectiveness and efficiency.
2. Effective integrated EAC SRHR/RMNCAH and HIV and AIDS knowledge management platform	The existing EAC HIV/AIDS Programme and the EAC OHI-RMNCAH Programme Knowledge Management Systems will be upgraded and into integrated/one stop Regional SRHR/RMNCAH, HIV/AIDS and Health Knowledge Management Platform. A robust EAC regional SRHR/RMNCAH; HIV/AIDS and Health web based platform/portal will be developed The Programme will support convening of meetings of Experts to define / refine SRHR/RMNCAH, HIV/AIDS research priorities in collaboration with the East African Health Research Commission and guide knowledge management processes. Other activities that will be supported include technical exchanges on priority areas for exchange of expertise among Partner States and convening of symposia on priority SRHR/RMNCAH and HIV/AIDS issues as a separate activity or in support of the East African Health and Scientific Conferences and International Health Exhibition and Trade Fair. The capacity building training on innovative Knowledge Management systems and practices will be conducted for Experts from the EAC Partner States and the EAC Secretariat.
3. Strengthening of SRHR/RMNCAH and HIV and AIDS leadership, governance and accountability effectively supported through regional actions	SRHR/RMNCAH and HIV and AIDS leadership, governance and accountability will be strengthened by use of innovative Advocacy documents, tools and materials such as the integrated RMNCAH and HIV/AIDS Scorecard; biennial (2 yearly) EAC regional state of SRHR/RMNCAH (Women Children and Adolescent Health and HIV & AIDS report and policy briefs. These documents will be developed concurrently to ensure efficiency. They will all be subjected to a drafting process led by Partner State Experts supported by consultants, country consultation and regional validation exercise. These tools together with other regional policy documents developed under this programme will collectively inform high level regional advocacy and dialogue fora.
4. Regionally developed	The EAC Health Sector Strategic Plan 2015-20 as well as the operational strategies such as the Integrated EAC Reproductive Maternal New-born

interventions accelerate the attainment of objectives of Universal Health Coverage in EAC	Child and Adolescent Health Strategic Plan 2016-2021 and the HIV and AIDS Strategic Plan 2015-2020 identify Universal Health Coverage (UHC) as key to accelerating progress in women, children's and adolescent health and HIV/AIDS. A number of activities will be undertaken to build the Capacity on sustainable financing of universal health and HIV coverage in the Partner States. These include: • Convening of the biennual High Level Dialogue Meeting on sustainable financing for health (bringing together Ministers of Health, finance directors of budget for the partner states and experts • Development and dissemination of EAC regional strategy/framework for sustainable financing of universal health and HIV coverage • Convene meetings of the EAC Expert working group on Sustainable financing on Health for the EAC region • Support EAC Partner states to adopt and implement sustainable financing options and other recommendations agreed upon during the HLD meeting
5. Effective coordination of global and regional SRHR/RMNCAH and HIV/AIDS interventions in the EAC	In order to deliver on the expected outputs and outcomes of the programme, a number of technical and administrative positions will be supported. These staff will be drawn from existing SRHR, HIV/AIDS projects namely the EAC Open Health Initiative for improving RMNCAH and the EAC HIV/AIDS, Tuberculosis and STI project respectively. The proposed staffing positions and their terms of reference is described in details under the section on staffing plan. They will facilitate regional coordination activities such as convening of meetings of the Joint Programme Steering Committee Meetings; Annual Programme Partners' Forum and Review Meetings; Technical/Expert Working Group Meetings; EAC Policy Organ meetings and monitoring and evaluation activities.

The detailed activities and timelines are summarized in the costed implementation plan hereto attached as **Annex I.**

3.5 Key Programme Actors

In this section**,** the programme beneficiaries, the roles and responsibilities of key stakeholders and the governance and coordination structure are described.

Programme Beneficiaries

Relevant National Ministries and Agencies Responsible for Reproductive Maternal New-born Child and Adolescent Health/SRHR and HIV/AIDS, STI and Tuberculosis, Gender, Immigration, Refugees and Disaster Preparedness Programmes in the EAC Partner States are the primary beneficiaries of the ESIHP. Regionally identified best practices and innovations in service packages, standards and guidelines; knowledge

management; research; leadership, governance and accountability; systems reforms towards universal health coverage and coordination of SRHR and HIV/AIDS will generated to inform and improve policies, strategies and programmes developed by these ministries and agencies.

Secondary beneficiaries of the Programme include CSOs with whom EAC works closely through identified networks such as the East African Health Platform (EAHP) and East African National AIDS Service Organisations (EANASO) as well as the private Sector while the ultimate beneficiary is the population of EAC, which is currently estimated at 145.5 million people. Civil Society Organisations, Private Sector and Development Partners influence implementation and outcomes of regional programmes through technical, policy and advocacy engagements that have been obviated by the EAC Consultative Dialogue Framework, a creature of Articles 127, 128 and 129 of the Treaty.

EAC provides various platforms for Partner States and the various actors (public, private CSOs, communities etc.) to share experiences and adopted best practices and innovations through regionally convened workshops, symposia and conferences; technical exchanges; peer-pressure to achieved regionally approved targets; efficiency through economies of scale in interventions such as pooled bulk procurement of life saving commodities and reduction in the cost of adoption and scale up of interventions through elimination of steps that would have been successfully implemented and learned about in the "early-adopter" Partner States. Partner States therefore do not have to invest separately in the adoption cycle including generation of evidence.

3.5.1 Roles and responsibilities of key stakeholders

The following key stakeholders will be actively engaged in implementation of the ESIHP. Partner State's Ministries, responsible for EAC affairs, Health, Gender, women and community development; Finance and economic development, Departments and Agencies and National Parliaments and Senates;

- EAC Organs (Summit of heads of state, EAC Council of Ministers, Sectoral Councils, EAC Secretariat, East African Legislative Assembly) and EAC Institutions (East Africa health Research Commission; inter University Council of East Africa (IUCEA), Lake Victoria Basin Commission, the Lake Victoria Fisheries Organization (LVFO);
- Development Partners;
- Academic and research institutions;
- Civil Society Organizations (CSO) and implementing partners;
- Private sector;
- Local communities.

Partner States

Partner States through relevant ministries and departments will implement regional SRHR and HIV/AIDS priority interventions and provide policy guidance on formulation of these priorities. They will mobilize and allocate resources technical and financial resources to facilitate implementation of the ESIHP and monitor its progress. National Parliaments are expected to make legislations and laws to create enabling environment; provide oversight and appropriate budgets for women children and adolescent health and the HIV/AIDS response. They will thus be involved in high-level advocacy fora to ensure that key policy issues remain high on the national and regional agenda.

EAC Organs and Institutions

The Summit of the Heads of States will provide the highest political leadership while the Council of Ministers will provide policy direction for effective implementation of the ESIHP - the Council will also issue directives and make decisions in accordance with the Treaty; and consider Plans and Budgets. The decisions and directives of the council will mainly be informed by policy guidance from the relevant Sectoral Councils of Ministers (Sectoral Council of Ministers of Health, Sectoral Council of Ministers of Gender, Council of Ministers of EAC Affairs and Planning). The Sectoral Councils will play an oversight role and approve all project related policy documents, advocate for ESIHP, allocate resources, monitor and keep under constant review the implementation of the project.

The decisions of the Sectoral Councils will in turn be informed by the Sectoral Committees which are comprised of senior Partner States experts and the Coordination Committees composed of Permanent/Principal Secretaries of the participating Ministries. Relevant Technical or Expert Working Groups drawn from the Partner States, EAC Secretariat, EAC institutions and Development Partners will first interrogate all technical matters. Examples of these include the EAC Reproductive Maternal New-born Child and Adolescent Heath and Nutrition Technical Working Group, the EAC HIV/AIDS, TB and STIs Technical Working Group.

Development Partners

EAC Secretariat will engage and bring on board development partners who will:

- Provide technical support in developing policies, strategies and guidelines;
- Provide financial resources, human resources, equipment and supplies;
- Support advocacy activities
- Guide implementation through participation in the MJSC and other stakeholder's fora.

Civil Society Organizations (CSOs):

Civil Society organizations are comprised of groups or organizations working in the interest of the citizens but operating outside of the governmental and for-profit sectors. Organizations and institutions that make up civil society include labour

unions, non-profit organizations, churches, and other service agencies that provide an important service to society but generally ask for very little in return. During implementation, the role of CSOs will:

- Advocate for implementation of the ESIHP activities at all levels (global, regional, national and community).
- Initiate public accountability and transparency in resource allocation and utilization
- Mobilize and build consensus and enhance public support for the project
- Document and disseminate best practices at regional, national and sub national level under the project

Private Sector

Private sector stakeholders are critical in the implementation of the programme and will contribute on the following ways:

- The EAC Secretariat will mobilize private sector stakeholders to contribute financial and other resources;
- Facilitate health infrastructure development, technology and innovation; and
- Engage in promotion and advocacy for implementation of Programme activities and initiatives;

Research and Academic institutions

National, regional and international Research and Academic institutions will:

- Implement the capacity building interventions as per the project document;
- Undertake operational and other forms of research to inform policy and programming in the region; and
- Support selects training initiatives with in the Programme.

3.6 Governance and Coordination Structures

The ESIHP will be governed in accordance with the provisions of the Treaty establishing the East African Community and other EAC policies, strategies, frameworks and plans. The relevant EAC Policy Organs described in Chapter 1 will provide the overall governance and policy oversight for the programme. The EAC Secretariat Joint Implementation team, Multisectoral Joint Steering Committee (MJSC) and the Regional Expert Working Group on RMNCAH and Nutrition, HIV/AIDS and Gender will provide operational and technical oversight.

3.6.1 EAC Secretariat Joint Implementation team

The EAC Secretariat will constitute a Joint Programme implementation team to coordinate implementation of the Programme. Experts from health, gender and community development, labour and employment and finance and human resource departments at the EAC Secretariat will constitute the team. It will hold quarterly

coordination meetings that will be chaired by the Deputy Secretary General for Productive and Social Sectors (DSG PSS).

3.6.2 Multisectoral Joint Steering Committee

A **Multisectoral Joint Steering Committee (MJSC)** will be established comprising of representatives from the:

a) EAC Secretariat (joint project implementation team);
b) Partner States' Ministry Responsible for EAC Affairs (level of National Head/Commissioner/Director (1 per Partner State);
c) SIDA and other key Development Partners
d) Relevant UN Agencies (regional) offering technical support to the project;

The main purpose of the Multisectoral Joint Steering Committee (MJSC) is to provide a good operational interface between the EAC Secretariat, Partner States and the development partners. The Committee will be responsible for facilitating planning, coordination and implementation of the ESIHP as well as management of the financial and technical contributions from the development partners.

The **Multisectoral Joint Steering Committee (MJSC) will be** convened once every six months under the auspices of the EAC Secretariat – office of the Secretary General to review progress on implementation.

Joint EAC technical Working Group on RMNCAH and Nutrition and HIV and AIDS, TB and STIs

The Joint EAC technical Working Group on RHNHACH and HIV and AIDS, TB and STIs will be constituted to include: Partner States' Techincal expert from the two twho TWGs on **RMNCAH and HIV and AIDS, TB and STIs and will co-opt members from relevant sectors guided by the agenda items for discussion.** The JTWG will also have one prepresentative from each of the following institutions of the EAC namely: EAHRC, IUCEA, LVBC.

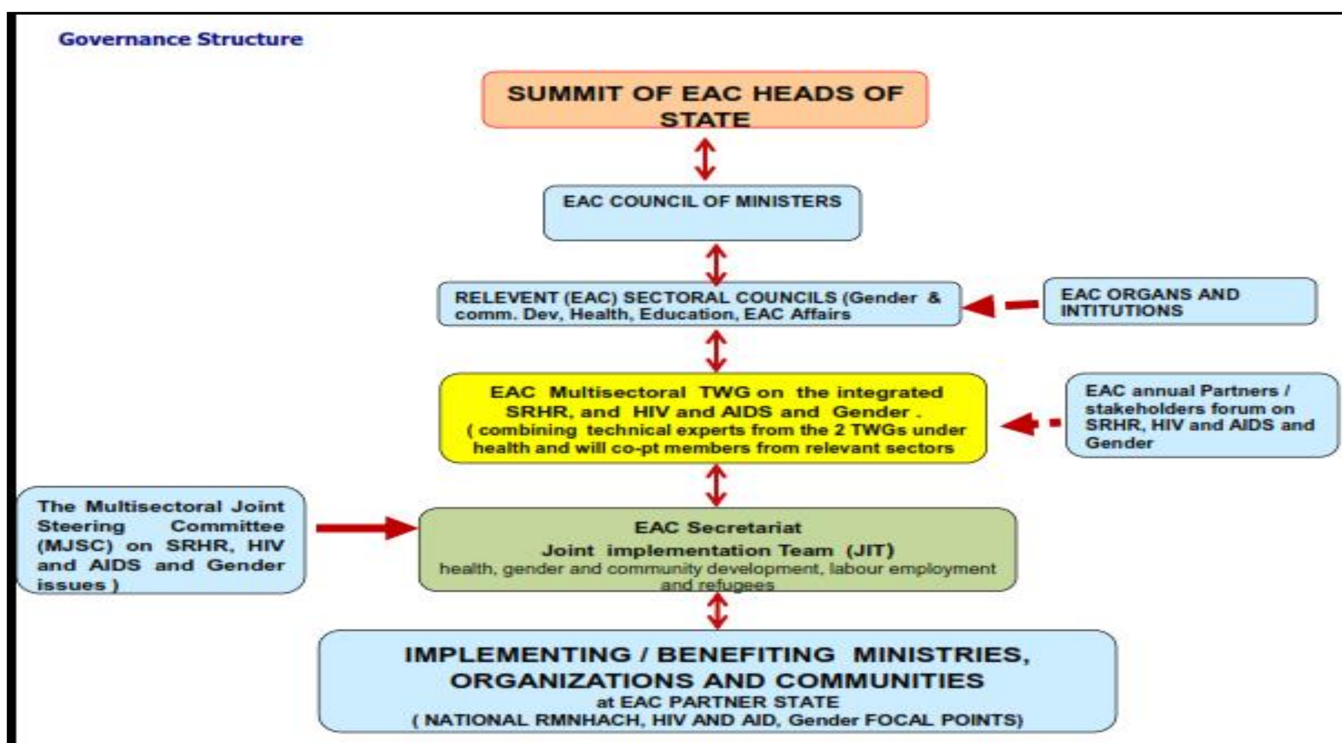
The purpose of the TWG is to facilitate proper planning, coordination and implementation of the EAC HIV and AIDS Regional response and shall report to the EAC Council of Ministers through the EAC Sectoral Council of Ministers of Health and other relevant Sectoral councils as may be necessary time to time. Specifically the tasks of the TWG are;

i. To periodically determine and recommend joint areas of regional cooperation on response to SRHR, Gender dimensions, HIV and AIDS and related issues.
ii. Review and provide input to regional documents and reports
iii. Develop strategies for harmonization of regional policies, strategic plans and programmes in response to women, children and Adolescent health, HIV and AIDS and related conditions

iv. To promote joint regional research on relevant thematic areas within the EAC through agenda setting, resources mobilization, coordination, monitoring and evaluation
v. To develop / strengthen a mechanism for regional information exchange between Partner States in the area of SRHR, Gender dimensions and HIV and AIDS,
vi. To formulate a regional strategy for resource mobilization for joint programmes on STIs, Tuberculosis and HIV/AIDS prevention and control.
vii. To deliberate on any other regional issue which may impact in the implementation of EAC Integrated Health Programme in East Africa

The EAC Secretariat shall convene semi-annual meetings of the **Regional Expert Working Group on SRHR, HIV and Gender.** However, extraordinary meeting may be may be held depending on issue that requires immediate broad-based technical redress in between the statutory meetings. The meetings will be chaired by Partner States according to the laid down EAC rules of procedure.

Figure 5: Governance and Coordination structure



3.7 Analysis of Strengths Weakness Opportunities and Risks

The summary of conditions under which the programme namely Strengths, weaknesses, opportunities and risks are described in **Table 10 and 11** below.

3.7.1 Strengths, weaknesses and internal risks

Strengths are factors, which the EAC Partner States and the Secretariat can optimize to deliver on this strategic plan while the weaknesses should be addressed to minimize their negative impacts on achievement of the desired outcomes in the implementation of the project. The table below summarizes the identified strengths and weaknesses.

Table 10: Summary of strengths and weaknesses of the Programme

Strengths	Weaknesses and Internal Risks
• Availability of RMNCAH and HIV & AIDS policy and strategic frameworks at regional and national levels. • Increasing capacity for knowledge management including research, innovations and technology • Legal mandate to coordinate regional cooperation in health provided for under Article 118 of the EAC treaty • Political stability in much of the region, strong leadership and political commitment • Availability of a team of qualified SRHR and HIV and AIDS Experts at the EAC Secretariat • Reliable financial management and procurement systems backed by relevant policy documents, regulations and guidelines • On-going sector wide harmonization processes e.g. medicines regulation harmonization, training, practice and licensure of health professionals • Effective national and regional cooperation mechanisms such as the technical working groups and policy organs	• Diverse and fragmented packages of essential RMNCAH services in the region. • Weak financial base and donor dependence affect the scope and scale of program implementation. • Paucity of tools and mechanism for strengthening accountability and leadership for results and resources • Low human resource capacity in monitoring and evaluation of health programmes. • Weak coordination with the private sector and civil society on RMNCAH and HIV/AIDS • Multiplicity of country HIV/AIDS strategic planning cycles across the Partner States minimizes effectiveness in coordinating the response including harmonized target setting • Disparities in operationalization of community health services across the region

3.7.2 Opportunities and Risks

Opportunities are factors in the external environment to the EAC secretariat and its Partner States that can be harnessed to support implementation of this proposed integrated framework. On the other hand, threats are factors that are likely to interfere with the achievement of the desired outcomes in the implementation of the framework. In both cases, they present as global or regional changes in policies, politics, laws, science and technology, economic climate, social trends among others that directly or indirectly impact on implementation of strategic plan. The table below outlines some of these factors.

Table 11: Summary of Opportunities and Risks to the project

Opportunities	**Challenges and External Risks**
• Commitment to establish sustainable funding mechanisms at both country and regional levels and integrate SRHR, HIV/AIDS, TB and STIs programming • The potential for local production of commodities and bulk procurement • Advances in new prevention and treatment technologies and innovations that could significantly reverse the trend of the HIV, TB and STI and eliminate preventable deaths among women, newborns and children • Vertical and horizontal linkages and synergies among relevant EAC organs institutions • Existence of strong relationships, partnerships and collaborations with other regional blocs including SADC, COMESA, ECSA-HC and AU among others to implement relevant commitments • Additional financing for SRHR and HIV and AIDS such as the Global Financing Facility for Women Children and Adolescent Health	• Diversion of attention and resources from RMNCAH and HIV/AIDS/TB and STIs by global health threats, the growing threat of non-communicable diseases, natural and manmade emergencies and terrorism and climate change • Dwindling Development Assistance for SRHR, HIV and AIDS health and overreliance on a few donors. • Political and civil instability • Lengthy EAC decision making processes • Frequent changes in global policies/guidelines affect the rate at which EAC Partner States adopt and implement such instruments

3.7.3 Risk mitigation strategies

Key internal and external risks to the successful implementation and realization of the anticipated results of the Programme will be mitigated through a number of strategies described below.

Low human resource capacity for high quality monitoring and evaluation of health programmes

Currently, the department has a Health Statistics and Data Management Assistant and a National Open Health Initiative officer with specialised training in M&E. Given the complexity of the ESIHP that brings on board SRHR/RMNCAH, HIV&AIDS, gender, migration, it is important that the existing M&E capacity is enhanced. In this regard, the programme will retain one of the National Open Health Initiative Officers with specialized training in M&E and experience in implementing SRHR, HIV&AIDS or health sector interventions. Programme staff and relevant staff from Partner States will be encouraged to take up additional trainings in monitoring and evaluation as part of the capacity building interventions under this programme.

Lengthy EAC decision-making processes

The EAC rules and procedures provide for consensus based binding policy decisions, which requires that all Partner States are part and parcel of policy-making processes. This often delays decision-making and therefore delivery of results. The EAC Secretariat will address this risk by forward planning and concurrent implementation of actions

Diversion of attention and resources from RMNCAH and HIV/AIDS/TB and STIs by global health threats, the growing threat of non-communicable diseases, natural and manmade emergencies and terrorism and climate change

The East African Community is a hot spot for outbreaks of communicable diseases and is subjected to a growing burden of non-communicable diseases, which are expensive to deal with. This impacts on the amount of resources and attention to RMNCAH and HIV/AIDS/TB and STIs. The Project management team composed of competent Experts will focus on strengthening regional cooperation mechanisms such as the Technical and Working Groups on RMMCAH and Nutrition and HIV/AIDS/TB and STIs and specialized Expert Working Groups.

Dwindling Development Assistance for SRHR, HIV and AIDS health overall and overreliance on a few donors

The programme will seek to address the issues of dwindling and unpredictable DAH by advocating for progressive increase in domestic financing of SRHR and HIV/AIDS at national and regional level. This will be facilitated through development of enabling

regional policies, strategies and tools to support advocacy, improving resource allocation and increasing fiscal space including maximization of efficiency savings. Sustainable health financing will be made a priority advocacy agenda for relevant EAC regional and national policy organs and institutions including the East African Legislative Assembly and National Assemblies and Senates. In addition, EAC will continue to engage various Partners to support different aspects of regional cooperation in SRHR and HIV and AIDS.

Political and civil instability

A number of strategic actions and activities have been proposed within the framework of this programme to increase the resilience of health systems and service delivery while reducing the impact of political and civil instability: a) development of packages, standards and guidelines for RMNCAH and HIV/AIDS that incorporate issues of health in emergencies and the rights of vulnerable communities and b) development of a regional policy and strategy to observe Human Rights of refugees/ IDPs in regard to Protection against HIV infection, and access to comprehensive SRH and HIV services. Innovative tools such as video conferencing, skype and teleconferencing facilities will be employed to ensure that all stakeholders including those who would have challenges with participating in physical meetings are adequately engaged.

Frequent changes in global policies/guidelines affect the rate at which EAC Partner States adopt and implement such instruments

This programme will provide opportunities for EAC Partner States to collaboratively define more effective and efficient ways of adopting and institutionalizing high impact policies and guidelines. EAC will provide guidance on the cost benefits analysis and timing for adoption of key policies and guidelines. Partner States will be discouraged from investing in changes whose benefits and costs have not been fully assessed and understood to avoid wastage and organizational disruptions associated with rapid changes.

3.8 Sustainability of the Programme

Additional resources will be mobilized through stronger partnerships, which this programme seeks to establish. Further, Partner will be encouraged to finance expansion of certain components of the programme. With this collaborative, leveraging or cost-share approach, the overall expenditure is kept to a minimum. Technical sustainability will be hinged on strengthening of the existing technical working groups and expertise of relevant departments and agencies in addition to development of robust regional policies, guidelines and standards.

In terms of institutional sustainability, the programme will sustain the existing expertise in SRHR/RMNCAH and HIV/AIDS through collaborations with partners

including UN Agencies, USAID, IAVI, CB HIPPs and sister Regional Economic Communities. Major advocacy activities will be carried out to uphold and sustain the momentum in regional cooperation on SRHR/RMNCAH and HIV & AIDS

CHAPTER 4: RESOURCE NEEDS

Introduction

Successful implementation of this programme will be based on effective resourcing in terms of financing and human resources which in turn impact on its sustainability.

4.1 Financial resources

The total resource envelope required for the ESHIP is estimated at USD **5,305,384** as distributed by objectives in **Table 12** below.

Table 12: Budget summarised by objective

Objective	Budget Estimate Year 1	Budget Estimate Year 2	Budget Estimate Year 3	Budget Estimate Year 4	Budget Estimate Year 5	Total Budget
Objective 1 Harmonize and Integrate RSH/RMNCAH/HIV/ AIDS Services, Standards and Guidelines in the EAC.	322,100	489,350	295,000	-	-	1,106,450
Objective 2: Strengthen SRHR/RMNCAH and HIV and AIDS research, innovations and knowledge management in the EAC	257,010	100,800	140,950	120,450	59,120	678,330
Objective 3: Strengthen SRHR/RMNCAH and HIV and AIDS Leadership, Governance and Accountability in the EAC	32,400	193,850	32,400	323,000	36,400	618,050
Objective 4: Strengthen the EAC Regional and National Health Systems towards universal coverage of SRHR/RMNCAH and HIV and AIDS services	134,700	-	94,400	-	-	229,100
Objective 5; Strengthen the Capacity of EAC Secretariat and Partner States to coordinate and implement the Program and related global and African regional initiatives	512,049	700,763	636,082	461,050	363,510	2,673,454
TOTAL	1,258,259	1,484,763	1,198,832	904,500	459,030	5,305,384
TOTAL	1,258,259	1,484,763	1,198,832	904,500	459,030	5,305,384

The programme will be funded through different funding lines and anticipates to receive a contribution of 10% from the Partner States vote and the rest is expected to come from development Partners and Private sector. The EAC Secretariat is planning a number of resource mobilization events including hosting a donor Round Table late this year. Additionally, the programme will tap into both financial and human resources of implementing partners in the region to support programme activities. The agenda on sustainable financing addressed in this programme will help augment resource mobilisation for national and regional SRHR/RMNCAH and HIV&AIDS.

4.2 Human Resources

4.2.1 Existing Human Resource Capacity for Regional Cooperation on Health

The EAC Secretariat health department has twenty seven (27) members of staffs who are stationed at regional and national level and operate under the 5 EAC Health department units as indicated in **Table 13.** Sixteen (16) of the total staff are directly implementing activities related to regional cooperation on SRHR/RMNCAH and HIV&AIDS.

Table 13: Summary of staffing levels for the health department

Staff position	National Level	Regional Office	Total Staff
HIV and AIDS Unit	0	5	5
RMNCAH Unit	6	5	11
Medicine and Food Safety Unit	6	4	10
Health Systems and Policy Unit	0	1	1
Disease Prevention and Control Unit	0	0	0
Total	**12**	**15**	**27**

Additionally, EAC Gender and Community Development and the Labour, Immigration and Refugee Management Departments are expected to contribute to implementation of some aspects of the programme and have one (01) staff each.

4.2.2 Human Resource requirements for the ESIHP

Although the ideal human resource requirements for sustaining the existing actions and results under the ESIHP requires the sustenance of the existing capacity of sixteen (16) staff, the scope and the immediately expected resources of ESIHP require prioritization. Consequently a total of eleven (11) key staff positions have been

identified to deliver on the results of this programme. The priority staff compliment is described in the table below.

Table 14: Priority Staff compliments for the EAC Integrated Health Programme

	Title	Number	Grade	Purpose	Comments
1	Principal HIV and AIDS Officer	1	P3	As the overall coordinator for implementation of the EAC Integrated Health programme and lead on the HIV and AIDS TB and STI component. The officer will be responsible for managing all technical and administrative functions of the programme, including the supervision of programme in liaison with the Principal Health Officer at the EAC Secretariat	Staff retained from the HIV and AIDS programme
2	Principal Health Systems and Policy Analysis Officer (PHSPAO)	1	P3	Deputy coordinator and Lead on policy analysis and development, specifically overseeing the maternal and child health Sexual Reproductive Health and Rights component under the programme.	Staff under Open Health Initiative
3	Capacity Building Officer (Training, Information, Advocacy, Communication And Social Mobilization)	1	P1	The officer will be responsible for the coordination and facilitation of institutional development support, including training, information, advocacy, communication, social mobilization and capacity enhancement for the implementation of EAC Integrates health |programme.	Staff retained from the HIV and AIDS programme
4	Open Health Initiative officer - Monitoring and Evaluation	1	P1	The primary responsibility of this position is to oversee the monitoring and evaluation component of the programme, including development of semi-annual and annual programme implementation reports	Staff under Open Health Initiative
5	Open Health Officer - Linkages and Partner Ships officer	1	P1	Officer responsible for linkages and partnerships during implementation.	Staff under Open Health Initiative
6	Health Statistics and Data Management Assistant	1	P1	The main responsibility of this person will be to carry out regular digital data Collection, storage, analysis, and	Staff under Open Health Initiative

				dissemination and share data and information on reproductive, maternal, new-born and child health and HIV and AIDS. This includes other relevant health statistical data and information in order to facilitate the attainment of the set objectives and targets of the regional integrated health programme.	
7	Programme Assistant: Gender and Community Development	1	G5	Assist in coordinating the implementation and monitoring of the programme; Assist in managing implementation of the programme through developing work plans	Proposed Position
8	Programme Assistant: Immigration and Refugee Management	1	G5	Coordinate and provide effective and efficient administration, management and Secretarial services for the smooth running of the EAC Integrated Health programmes	Proposed Position
9	Office Management Assistant	1	G5	Coordinate and provide effective and efficient administration, management and Secretarial services for the smooth running of the EAC Integrated Health programmes	Staff retained from the HIV and AIDS Programme
10	Programme Accounts Assistant	**1**	G5	The main purpose of this job is to facilitate efficient and effective financial administration and management of all funds of the EAC HIV/AIDS, Sexually Transmitted Infections (STIs) and Opportunistic Infections (OIs) Prevention and Control Programme and other related responsibilities as may be assigned from time to time.	Staff retained from the HIV and AIDS programme
11	Driver / Officer Messenger	**1**	G2	Support staff for the project.	Staff retained from the HIV and AIDS programme

	Total compliment	**11**			

The detailed job descriptions of the above staff are hereto attached as **Annex II.**

4.3 Staff skills and capacity enhancement

Although the staff will be drawn from the existing EAC SRHR/RMNCAH, HIV and AIDS, Gender and Community Development and Migration and Refugees departments, they will work together with counterparts in the Partner States, and will need capacity building in selected areas in order to effectively implement the programme. Some of the tentatively identified key and specialized areas for capacity building include resource mobilization, health financing, health systems strengthening, procurement, monitoring and evaluation and knowledge management approaches.

CHAPTER 5: MONITORING AND EVALUATION

5.1 Introduction

This chapter focuses on the key highlights of Monitoring and Evaluation of the ESIHP for the period 2016-2020.

The specific objective of the M&E system is to generate evidence that will promote evidence based decision making at all levels. It provides data that is essential for drawing lessons, priority setting and informed review of processes during implementation. It further provides a mechanism for assessing the extent to which allocated resources are used for the intended purpose effective implementation of the programme.

Monitoring and evaluation will be based on the Monitoring and Evaluation Framework and the Monitoring and Evaluation Plan which are attached as **Annexes III and IV.**

The Monitoring and Evaluation framework for the EAC IHP consist of the expected results and indicators of measuring performance, baselines, milestones, targets and means of verification.

The programme Monitoring and Evaluation Plan highlights the key M&E activity schedule responsible persons and entities reported to.

The Monitoring and Evaluation team of the ESIHP will be required to:

ii. Ensure timely availability of data;
iii. Analyze, disseminate and promote the use of the M&E data by stakeholders;
iv. Ensure adequate and reliable access to data by different users; and
v. Link the M&E data with ESIHP to enable and facilitate monitoring at regional and partner state levels.

5.2 Monitoring

Monitoring of the ESIHP will be a continuous process during the implementation of the Programme where data will be collected at all levels on a regular basis. This data will be used to verify progress and make evidence based decisions in making corrections and adjustments in the implementation strategy on timely basis.
Monitoring reports will be shared timely with all stakeholders and actions implementation followed up.

5.3 Evaluation

Evaluation of the ESIHP will be as follows:

i. ***Formative or Baseline Evaluation:*** The programme will rely on the existing evaluation report for the end of HIV and AIDS Strategic Plan 2008-2015 and other relevant reports from the EAC Sectors to inform the baseline status. This will play a big role in setting targets that will be used during the subsequent evaluations.

ii. ***Mid-Term Evaluation: This*** *will be* implemented mid-way in the life cycle of the of ESIHP. It will inform whether or not the implementation of the Programme is on course or not and recom*mend corrective acti*on to improve implementation.

iii. ***Terminal Evaluation*** will be conducted at the end of the four year period to take stock of the ESHIP. It will inform on whether or not there was value for money in the implementation of the Programme interventions and specifically establish the success rate of the plan in

achieving its strategic objectives (outcomes) as measured by the indicators.

Annex I: Costed Implementation Plan

Objectives	Strategic Actions and Activities	Time frame					Total cost	Responsible Person / Agency
		2016/17	2017/18	2018/19	2019/2020	2020/2021		
Objective 1: Harmonize and integrate SRHR/RMNCAH and HIV/AIDS Service Packages, Standards and Guidelines in the East African Community	**1.1 Develop harmonized integrated SRHR/RMNCAH and HIV/AIDS Packages, Standards and Guidelines**							Health department - RMNCAH and nutrition unit
	1.1.1 Conduct a baseline assessment of existing packages of RMNCAH services, standards and guidelines in the EAC providing for Rights Based Approaches, eMTCTC, SGBV, Nutrition, Emergency Response/Health Systems Resilience, immunization and Quality Assurance.						110,900	
	1.1.2 Convene 2 expert meetings to develop and finalize the baseline assessment tools and to provide input to the zero draft prior to the country consultations						77,900	
	1.1.3 Conduct country consultations on the draft baseline assessment report						105,900	
	1.1.4 Convene a meeting to validate the draft baseline basement report on packages of service						48,250	
	1.1.5 To develop an EAC regional minimum package of integrated of RMNCAH services, standards and guidelines using the draft baseline assessment report						26,300	
	1.1.6 Convene an expert meetings to provide input to the draft EAC regional minimum package of integrated of RMNCAH services, standards and guidelines prior to the country consultations						77,900	
	1.1.7 Conduct country consultations						105,900	
	1.1.8 Convene a regional validation meeting draft EAC regional minimum package of integrated of RMNCAH services, standards and guidelines.						54,600	
	Subtotal						**607,050**	
	1.2 Develop the minimum package, Standards and Guidelines for HIV and AIDS, STI, TB in the EAC region							Health department - HIV and AIDS unit (combined team)
	1.2.1 Conduct a baseline assessment on situation of STIs, prevention, diagnosis and treatment practices in the context of the HIV and AIDS response in the EAC region.						56,000	

	1.2.2 Convene an expert meeting to provide inputs into the draft report on the situation on STI Prevent, diagnosis and treatment practices in the EAC region						77,900	
	1.2.3 Conduct country consultations on the baseline assessment on situation of STIs, prevention, diagnosis and treatment practices the STIs in the region						68,700	
	1.2.4 Convene a regional meeting to validate a regional report on the draft report on the situation of the STI, prevention, diagnosis, and treatment in the EAC region						58,200	
	1.2.5 Develop a harmonized EAC regional algorithm for prevention, treatment and diagnosis of STIs using the regional situation analysis report.						22,200	
	1.2.6 Convene expert meetings to review and provide inputs to the EAC regional algorithm for prevention, diagnosis and treatment of STYs.						77,900	
	1.2.7 Conduct country consultations on the draft EAC regional algorithm for prevention, diagnosis and treatment of STI's.						68,700	
	1.2.8 Convene a regional validation meeting for the EAC Regional algorithm for prevention, diagnosis and treatment of STIs.						65,800	
	Sub Total						**499,400**	
	Total objectives 1						**1,120,600**	
Objective 2: Strengthen SRHR/RMNCAH and HIV and AIDS Research, Innovations and Knowledge Management in the EAC	**2.1 Upgrade the existing EAC HIV/AIDS Programme and the EAC OHI-RMNCAH Programme Knowledge Management Systems into an Integrated EAC Regional SRHR/RMNCAH, HIV/AIDS and Health Knowledge Management Platform**							
	2.1.1 Convene a regional workshop to define / Refine SRHR/RMNCAH, HIV/AIDS research priorities						67,260	
	2.1.2 convene Expert working Group Meetings (2 Meetings per year on knowledge management per year)						267,850	All including partners
	2.1.3 Develop a robust EAC regional SRHR/RMNCAH, HIV/AIDS and Health web based platform/portal						122,300	
	2.1.4 Support convening of symposia during the East African international Health and Scientific conference						68,220	
	2.1.5 Support technical exchanges among Partner States, and with other relevant institutions including Regional Economic Communities.						152,700	
	Sub Total						**678,330**	

Objective	Activity						Budget	Responsible
	Total Objective 2						**678,330**	
Objective 3: Strengthen SRHR/RMNCAH and HIV and AIDS Leadership, Governance and Accountability in the EAC	**3.1 Develop innovative Advocacy documents, tools and materials**							
	3.1.1 Develop biennial (2 yearly) EAC regional state of SRHR/RMNCAH (Women Children and Adolescent Health and HIV & AIDS Report)						89,200	PHAO and PHPAO
	3.1.2 Convene one regional workshop to review the draft EAC regional state of SRHR/RMNCAH (Women Children and Adolescent Health and HIV & AIDS report						145,300	
	3.1.3 Conduct Country consultation and validation of the EAC regional state of SRHR/RMNCAH (Women Children and Adolescent Health and HIV & AIDS Report and the draft annual integrated EAC Regional SRHR/RMNCAH and HIV and AIDS Scorecard						105,900	
	3.1.4 Conduct regional validation workshop for the EAC regional state of SRHR/RMNCAH (Women Children and Adolescent Health and HIV & AIDS Report						107,650	
	3.1.5 Develop annual integrated EAC Regional SRHR/RMNCAH and HIV and AIDS Scorecard						170,000	
	Sub Total						**618,050**	
	Total Objective 3						**618,050**	
Objective 4: Strengthen the EAC Regional and National Health Systems towards universal coverage of SRHR/RMNCAH and HIV and AIDS services	**4.1 Build the Capacity of the Partner States on Sustainable and Alternative financing of SRHR/RMNCAH, HIV and AIDS and Health**							
	4.1.1 Convene a High Level Dialogue (HLD) on sustainable financing of SRHR/RMNCAH, HIV and AIDS and Health						94,400	
	4.1.2 support convening of the 1st Summit of heads of State on investment in health						30,400	
	4.1.3 Develop EAC regional strategy for sustainable financing of SRHR/RMNCAH, HIV and AIDS and Health						28,700	
	4.1.4 Conduct country consultations on the draft EAC regional strategy for sustainable financing of SRHR/RMNCAH, HIV and AIDS and Health						75,600	
	Sub Total						**229,100**	
	Total Objective 4						**229,100**	

Objective 5: Strengthen the capacity of the EAC Secretariat and Partner States to coordinate and implement the project and related global and Africa regional Initiatives	**5.1 Develop the human resource and operational capacity of EAC Secretariat and Partner States to coordinate and implement the project**							
	5.1.1 Pay staff salaries and benefits						1,955,679	
	5.1.2 Support Programme staff and Partner States Experts to undertake graduate studies (PhD and Masters degrees) in various areas relevant to strengthening of SRHR/RMNCAH and HIV/AIDS Health Systems and Policies in Collaboration with Swedish and other institutions of higher learning.						141,375	
	5.1.4 Support programme staff and partner states Experts supported to undertake short courses (ranging from 1 week to 12 week) in defined areas of need to support programme implementation.						80,400	
	5.1.5 Procure and install office equipment and supplies						146,120	
	Sub Total						**2,323,574**	
	5.2 Provide Programme Coordination and Oversight Support							
	5.2.1 Convene bi-annual Programme Joint Steering Committee Meetings						109,000	
	5.2.5 Conduct Midterm and End-term Programme Evaluation						139,830	
	5.2.6 Regional Dissemination of Midterm and End Term evaluation reports						101,050	
	Sub Total						**349,880**	
	Total Objective 5						**2,673,454**	
	GRAND TOTAL FOR 4 YEARS						**5,305,384**	

Annex II: Job Descriptions

Annex III: Monitoring and Evaluation Framework

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
Purpose		• Number of Partner States that have or are in the process of adapting/adopting and using the regional policy, strategy, guidelines, standards, approaches, innovations and manuals	Sectoral Council Reports, Activity Reports	0	6	0	1	2	2	1
		• Number of EAC policy and strategic documents[48] adopted/adapted and implemented by Partner States		0	4	0	1	2	1	0
Strategic objectives	**Objective 1:** Harmonize and integrate SRHR/RMNCAH and HIV/AIDS Service Packages, Standards	1.1 Number of Harmonized and integrated packages, standards, guidelines approved.	Sectoral Council Reports, Partner State Activity Reports	0	4	0	2	2	0	0

[48] Integrated RMNCAH Service Package Strategy guidelines and standards, HIV&AIDS and STIs Service Package strategy guidelines and standards, Knowledge Management Strategy, Sustainable financing in UH&HIV Coverage framework,

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
	and Guidelines in the East African Community									
	Objective 2: Strengthen SRHR/RMNCAH and HIV and AIDS research, innovations and knowledge management in the EAC	2.1 EAC Knowledge Management strategy on health focusing on SRHR and HIV and AIDS, gender and migration health in place.	Sectoral Council Reports,	0	1	1	0	0	0	0
		2.2 Effective and integrated Regional knowledge management platform for health focusing on SRHR and HIV and AIDS, gender and migration health in place (Migration health covers health of Refugees and IDPs).	Sectoral Council Reports Physical existence of Platform	0	1	1	0	0	0	0

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
		2.3 Number of interventions that have been regionally evaluated, adopted and scaled up as innovations/best practices[49]	Sectoral Council Reports	0	12	1	4	4	3	0
	Objective 3: Strengthen SRHR/RMNCAH and HIV and AIDS Leadership, Governance and Accountability in the EAC	3.1 Number of innovative advocacy and accountability tools and frameworks including Resource Tracking /Monitoring[50]	Sectoral Council Reports Physical tools as mentioned in Footnote.	2 Annual RMNCAH Scorecards	6	2	1	2	1	0
	Objective 4: Strengthen the EAC Regional and National Health Systems towards universal coverage of SRHR/RMN	4.1 Proportion of Council decisions and directives on sustainable financing implemented by the Partner States	Activity Reports Sectoral Council Reports	0	100%	60%	70%	80%	100%	

[49] Each of the 6 Policy and strategic documents is expected to promote the adoption of at least 2 innovations/best practices.
[50] Advocacy and Accountability tools will include the scorecard (4), detailed health status reports (2).

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
	CAH and HIV and AIDS services									
		4.2 Proportion of Partner States that are spending at least 5% of their GDP on Health or THE per capita of USD86).	Sectoral Council Reports National Health Accounts	40%	80%	40%	60%	70%	80%	
	Objective 5: Strengthen the capacity of the EAC Secretariat and Partner States to coordinate and implement the project and related global and Africa regional Initiatives	5.1 Functional coordination and implementation mechanism (Joint implementation committee, joint steering committee and joint technical working group)	Sectoral Council Reports Programme Reports	0	3	3				
Activities	1.1 Develop a harmonized and integrated minimum	1.1.1 SRHR/RMN CAH and HIV/AIDS Baseline assessment Report	Project Reports Sectoral Council Reports	0	1	1				

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
	package of SRHR/RMN CAH and HIV/AIDS service Standards and Guidelines									
		1.1.2 Harmonized and integrated minimum package of SRHR/RMN CAH and HIV/AIDS service, Standards and Guidelines	Project Reports Sectoral Council Reports	0	1	0	*1*			
	1.2 Develop the minimum package, Standards and Guidelines for HIV and AIDS, STI, TB in the EAC region	1.2.1 Baseline assessment report on situation of STIs, prevention, diagnosis and treatment practices in the EAC region	Project Reports Sectoral Council Reports	0	1	1				
		1.2.2 Harmonized EAC regional algorithm for prevention, treatment and diagnosis of STIs	Project Reports Sectoral Council Reports	*0*	*1*		*1*			

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
Activities	2.1 Upgrade the existing EAC HIV/AIDS Programme and the EAC OHI-RMNCAH Programme Knowledge Management Systems into an Integrated EAC Regional SRHR/RMNCAH, HIV/AIDS and Health Knowledge Management Platform	2.1.1 Hand book on Research priorities for RHR/RMNCAH, HIV/AIDS for the EAC region – Research Agenda	Activity Report Research Reports	*0*	*2*	*1*		*1*		
		2.1.2 Symposia on SRHR/RMNCAH and HIV/AIDS		*0*	*2*	*1*		*1*		
		2.1.3 Number of technical exchanges on priority areas of learning under		0	*2*	*1*		*1*		

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
		SRHR/RMNCAH, HIV/AIDS, and migration issue (bringing 2 experts per Partner State) supported by the programme								
		2.1.4 Operational EAC Integrated SRHR/RMNCAH, HIV/AIDS and Health web based platform/portal	Sectoral Council Report Physical existence of the web portal	*0*	*1*	*1*	*1*	*1*	*1*	
Activities	3.1 Develop innovative Advocacy documents, tools and materials[51]	.1 Total number of Policy briefs developed on high value regional SRHR/RMNCAH and HIV/AIDS Policy Issues	Activity Reports Scorecard Sectoral Council Reports	*0*	*4*	*1*	*1*	*1*	*1*	
		3.1.2 Number of integrated EAC Regional SRHR/RMNCAH and HIV and		*2*	*4*	*1*	*1*	*1*	*1*	

[51] Dissemination of all material will be undertaken through pre planned EAC organ meetings, Conferences, electronic media among others

	Intervention Logic	Objectively verifiable indicators		Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
			AIDS Scorecards developed								
		3.1.3	Number of Biannual EAC regional state of SRHR/RMNCAH (Women Children and Adolescent Health) and HIV & AIDS Reports developed		*0*	*2*	*1*		*1*		
	4.1 Build the Capacity of the Partner States on Sustainable and Alternative financing of SRHR/RMNCAH, HIV and AIDS and Health	4.1.1	High level Dialogue on sustainable financing for universal health and HIV	Report of High Level Dialogue on sustainable financing for universal health and HIV coverage Sectoral Council Reports	*0*	*1*	*1*				
Activities		4.1.2	EAC Regional Framework of action on sustainable financing for	Sectoral Council Reports; Annual programme	*0*	*1*	*1*				

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
		universal health and HIV coverage.	progress reports							
		4.1.3 Number of Expert Working Group meetings conducted	Annual programme progress reports	*0*	*3*	*1*	*1*	*1*		
Activities	5.1 Develop the human resource and operational capacity of EAC Secretariat and Partner States to coordinate and implement the project	5.1.1 Number of Staff deployed to coordinate the implementation of the programme.	HR Reports; and Annual programme progress reports	*11*	*11*	*11*	*10*	*7*	*6*	*6*
		5.1.2 Number of staff and Experts trained	HR Reports	*0*	*2*	*2*	*2*	*2*	*2*	*0*
		5.1.3 Equipment procured (number and type)[52]	Annual programme progress reports			*1*				

[52] Procured equipment will include Laptops (4), Desktops (4) and LCD Projector (1)

	Intervention Logic	Objectively verifiable indicators	Sources and means of Verification	Baseline	Overall Targets	Target Yr1 (2016/17)	Target Yr2 (2017/18)	Target Yr3 (2018/19)	Target Yr4 (2019/20)	Target Yr5 (2020/21)
		5.1.4 Number of staff attending short courses		*0*	*8*	*0*	*4*	*0*	*4*	*0*
	5.2 Provide Programme Coordination and Oversight Support[53]	5.2.1 Number of Joint Steering Committee Meetings convened.	. Minutes of Meetings.	*0*	*8*	*1*	*2*	*2*	*2*	*1*
		5.2.2 Conduct annual project Audit	Audit Reports		*5*	*1*	*1*	*1*	*1*	*1*
		5.2.3 Mid and End term evaluation	Mid and End term Evaluation reports	*0*	*2*	*0*	*0*	*1*	*0*	*1*
			Number of disseminations carried out.	*0*	*2*		*0*	*1*	*0*	*1*

[53] No baseline assessment will be conducted. The programme will rely on the existing evaluation report for the end of HIV and AIDS Strategic Plan 2008-2015 and other relevant reports from the EAC Sectors to inform the baseline status.

Annex IV: Monitoring and Evaluation Plan

SN	Activity	Activity schedule	Responsible Parties	Reporting schedule	Entities Reported to
1	Monitoring of outcomes	Annually	PHAO, PHSPAO, M&E Officer, HSDMA	Annually	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee
2	Monitoring of Political, Economic, Social Technological, Legal & Environmental Factors	Annually	PHAO, PHSPAO, M&E Officer, HSDMA	Annually	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee
3	Monitoring of outputs, interventions, activities and inputs	Monthly	PHAO, PHSPAO, M&E Officer, HSDMA	Quarterly/bi-annually	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee
4	Update of the Baseline Indicators	Between July-October 2016	PHAO, PHSPAO, M&E Officer, HSDMA	December 2016	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee
5	Annual reviews	Annual	PHAO, PHSPAO, M&E Officer, HSDMA	Annually	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee
6	Mid-term evaluation	Between September -November	PHAO, PHSPAO, EAC M&E Officer,	December 2018	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee

		2018	HSDMA		
7	End-term evaluation	Between September -November 2020	PHAO, PHSPAO, EAC M&E Officer, HSDMA	December 2020	Sectoral Council on Health; Technical Working Group on RMNCAH and HIV&AIDS; Joint Steering Committee