EAST AFRICAN COMMUNITY REGIONAL HIV AND AIDS RESPONSE REPORT 2013

Realizing the Regional Goals in HIV and AIDS, TB and STI Programming

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PREFACE

The East African Community's aspiration to improve the quality of life of the people of the East African region lies at the heart of our pursuit for wider and deeper economic, political, social and cultural integration. The Treaty for the Establishment of the East African Community recognizes the manifest correlation between a healthy population and a competitive region.

Competitiveness, which spurs increased trade and investment, starts with economic productivity. Economic productivity is a futile pursuit in the absence of robust health infrastructure, including mechanisms for sharing information and knowledge at a regional level. Article 118 of the Treaty exhorts the Partner States to take joint action to prevent and control pandemics and epidemics of communicable and non-communicable diseases, among these HIV and AIDS.

The EAC Regional HIV and AIDS Response Report 2013 is therefore very important because it collates relevant data on the epidemic and creates, for the first time, a consolidated reference for any discussion on the status, trends and response to the HIV and AIDS epidemic in the region. Even more fundamentally, it provides the facts needed for evidence-based decision making on critical issues such as re-programming the region's response to the HIV and AIDS epidemic.

This report is the product of the commitment of resources such as time and knowledge by a variety of stakeholders—many of who are leading experts in their fields. It is a document of the highest quality, having been subjected to rigorous scrutiny, first through various validation workshops at national and regional levels, and finally through a stringent peer review process. A report of such significance demanded no less.

I trust that this report will prove to be a most useful tool for policy and decision makers in the Partner States and at regional and international levels, and that it will multiply the region's resource in the ongoing efforts to beat back an epidemic which, perhaps more than any other, actively threatens the realization of the lofty ambitions we espouse as a regional bloc.

Dr. Richard Sezibera
Ambassador
EAC Secretary General

FOREWORD

As the world witnesses the fourth decade in the existence of HIV and AIDS, the East African Community appreciates the challenges wrought by this epidemic better than most. We are a bloc whose Partner States were among the worst hit by this scourge, with prevalence rates registering highs between 10% and 18% for some Partner States in the 1980s and 90s.

Yet our response, at national and regional levels, has been nothing short of exemplary. It is a response that has consistently married unwavering political commitment, innovative policy prescriptions and pragmatic social interventions to cause significant reductions in the number of AIDS-related deaths and the number of people who were newly infected with HIV in all the Partner States in the last decade (from 390,000 to 330,000 in the case of the latter).

It is also encouraging to note that total budgets and actual funding for the HIV and AIDS response continue to grow, notwithstanding the fact that there remains a significant gap between projected costs and mobilized resources. Similarly, the East African Community is encouraged by the deliberate and proactive efforts of the private sector in the region to institute workplace policies that curtail stigma/discrimination, while enhancing support for those infected with/affected by HIV and AIDS in the workplace. Such efforts re-emphasize the crucial role of the private sector in staving off undesirable consequences of the HIV and AIDS epidemic, such as reduced labor productivity, and reaffirm the vision of the EAC's founding fathers for a competitive region spurred on by a socially responsive private sector.

Nevertheless, we recognize that the gains so far achieved, while commendable, can still be significantly improved upon. To do that, we must, by design, enhance the mechanisms through which we share information, knowledge and experiences among ourselves. The EAC Regional HIV and AIDS Response Report 2013 is an excellent avenue to do that.

This report is a novel step in augmenting the region's knowledgebase on HIV and AIDS. But it will do more: it will serve as a critical platform for HIV and AIDS-related advocacy, and also serve as an additional tool for enhancing accountability on national, regional and international commitments on HIV and AIDS that our Partner States have made.

On behalf of the EAC Sectoral Council of Ministers responsible for Health, I would like to express my gratitude to the Partner States; regional and international bodies and; the technical experts that contributed to the compilation of this report.

It is my hope that the production of this report will be institutionalized, and I trust that users will find it a most valuable resource.

Hon. James Macharia
Chairperson
EAC Sectoral Council of Ministers responsible for Health

ACKNOWLEDGMENTS

The East African Community Secretariat would like to acknowledge the valuable input of Partner States, regional bodies, UNAIDS, USAID, SIDA, members of the various technical experts groups and members of the peer review group who contributed to shaping the structure, interrogating the main ideas and defining the content of the first-of-its-kind EAC Regional HIV and AIDS Response Report 2013.

The Secretariat wishes to specifically thank members of the EAC Monitoring and Evaluation (M&E) Technical Working Group (TWG) on HIV and AIDS, TB and STIs who reviewed the Inception Report and the first draft report; the participants at the validation workshop for the revised draft report; participants at various national validation workshops for the final report and; the peer review group.

The members of the EAC M&E Sub group of the TWG on HIV and AIDS, TB and STIs are: Dr. Patrick Muriithi Kaburi, Mr. Apollinaire Kavungerwa, Dr. Samwel James Sumba, Mr. Ali Kimwaga, Mr. Denis Busobozi, Mr. Jean Pierre Nyemazi.

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This report is the product of the commitment and hard work of the staff of the Health Department at the EAC Secretariat. Particularly deserving commendation is the EAC HIV and AIDS Unit.

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ACRONYMS

ADP	AIDS Development Partner
AIC	AIDS Information Centre
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Clinic
ART	Anti Retroviral Treatment
ARV	Anti Retro Viral
ASRH	Adolescent Sexual Reproductive Health
AU	African Union
BCC	Behavior Change Communication
BDHS	Burundi Demographic and Health Survey
BRICS	Brazil, Russia, India, China and South Africa
CCAC	Communal Committees on AIDS Control
CCT	Conditional Cash Transfer
CDC	Centers for Disease Control
NAC	National AIDS Commission
CNLS	Conseil National de Lutte contre le Sida
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CPT	Co-trimoxazole Preventive Therapy
CSF	Civil Society Fund
CSO	Civil Society Organization
DfID	Department for International Development
DR	Drug Resistance
EA	East Africa
EAC	East African Community
EALA	East African Legislative Assembly
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
GARPR	Global AIDS Response Progress Report
GDP	Gross Domestic Product
GFATM	Global Fund for Fighting AIDS, Tuberculosis and Malaria
HAU	HIV and AIDS Unit
HC	Health Centre
HCT	HIV Counseling and Testing
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
HMIS	Health Management Information System
ICC	Inter-agency Coordinating Committee
IDU	Intravenous Drug User
IEC	Information, Education and Communication
IMF	International Monetary Fund
JAR	Joint AIDS Review
KDHS	Kenya Demographic and Health Survey
KNASP	Kenya National HIV and AIDS Strategic Plan
LG	Local Government

LVBC	Lake Victoria Basin Commission
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MDR	Multiple Drug Resistance
MOES	Ministry of Education
MOGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MoT	Mode of Transmission
MSM	Men having sex with Men
MTCT	Mother to Child Transmission
MTR	Mid-term Review
NAC	National AIDS Council
NACC	National AIDS Control Council
NACP	National AIDS Control Program
NASA	National AIDS Spending Assessment
NCD	Non-communicable Disease
NGO	Non-governmental Organization
NMSF	National Multi-sectoral Strategic Framework
NPAP	National Priority Action Plan
NRL	National Reference Laboratory
NSP	National Strategic Plan
NTLP	National Tuberculosis and Leprosy Programme
OPM	Office of the Prime Minister
OVC	Orphan and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counseling
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RBC	Rwanda Biomedical Centre
RDHS	Rwanda Demographic and Health Survey
SCE	Self Coordinating Entity
SGBV	Sexual and Gender Based Violence
SMC	Safe Male Circumcision
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
TB	Tuberculosis
THMIS	Tanzania HIV and AIDS and Malaria Indicator Survey
TNCM	Tanzania National Coordinating Mechanism
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UAIS	Uganda AIDS Indicator Survey
UCT	Unconditional Cash Transfer

UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shillings
UHSBS	Uganda HIV Sero-Behavioral Survey
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly
UNICEF	United Nations Children Fund
UNPDA	United Nations Political Declaration on HIV and AIDS
USAID	United States of America International Development
USG	United States Government
US$	US Dollar
VHT	Village Health Team
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZNSP	Zanzibar National HIV&AIDS Strategic Plan

EXECUTIVE SUMMARY

Background: Even if the HIV and AIDS epidemic is in its fourth decade today, there is international commitment for progressively moving to a world with zero new HIV infections, zero AIDS deaths and zero discrimination. In the East African Community, there was a reduction in the number of people who were newly infected with HIV from 390,000 to 330,000, representing a decrease of 14% between 2001 and 2012. There has been a consistent decline in the number of AIDS-related deaths in all the countries in the EAC since 2005, when ART became more widely available.

This first EAC Regional HIV and AIDS Response Report 2013 is important for consolidating information on the status and trends of the HIV epidemic in the region, assessing progress made in reaching national, regional, continental and global commitments on the epidemic, and reviewing the political commitment and actions by Partner States in the response to the HIV epidemic in the region. The report covers the period up to December 2012.

HIV epidemic overview in East Africa: The East African Community Partner States have made considerable progress towards attaining the 2011 United Nations (UN) Political Declaration on HIV and AIDS as is shown in the table below:

Status at a Glance: EAC Partner States' Progress towards UN Targets on HIV and AIDS

UN TARGETS	BURUNDI	KENYA	RWANDA	UGANDA	TANZANIA
1. Halve sexual transmission of HIV					
2. Halve transmission of HIV among people who inject drugs					
3. Eliminate new HIV infections among children/halve AIDS-related maternal deaths					
4. Increase universal access to HIV treatment by PLHIV					
5. Halve TB deaths among PLHIV					
6. Close the national AIDS resource gap					
7. Eliminate gender inequalities and sexual violence and increase capacity of women and girls					
8. Eliminate stigma and discrimination through promotion of laws and policies based on HR					
9. Eliminate HIV-related restrictions on entry, stay and residence					
10. Eliminate parallel systems for stronger integration of health, AIDS and development efforts					

Source: Country Progress Report (2011-2013) on The United Nations General Assembly 2011 Political Declaration on HIV/ AIDS

Note Color Code: GREEN: On Track; RED: Not on Track; PURPLE: Not Indicated; YELLOW: No Data; : BLUE: Not Applicable

Regional response to HIV epidemic: The multi-sectoral approach adopted by all EAC Partner States in responding to HIV epidemic provides a good opportunity for health and non-health sectors to participate in the response to the HIV epidemic. The East African Legislative Assembly (EALA) passed the HIV Prevention and Management Bill 2012 to guide EAC Partner States in the response to the epidemic. The Bill has been presented to Partner States for assent.

Elimination of new HIV infections: In East Africa, most new infections occur in couples who engage in heterosexual intercourse within a union/regular partnership and among (i) those who practice casual sex e.g. truckers, drivers, migrant workers, etc, (ii) sex workers and their clients and (iii) the prison population and men having sex with men (MSM) in some countries. Multiple, concurrent and unprotected sexual relationships are common in the region. Combination prevention interventions are being scaled up in the region.

Eliminating new infections among children and keeping their mothers alive: The number of new HIV infections

among women aged 15–49 in the East African region declined by 4-10% between 2009 and 2012. However, there has been considerable improvement in the proportion of pregnant women that received ARVs to prevent MTCT across the region, having moved from less than 35% in 2009 to more than 50% in 2012. Many HIV positive women are also receiving ART for their own benefit.

Provision of anti-retroviral treatment: The scale-up of ART in the EAC is saving and prolonging the lives of many people living with HIV in the region while also limiting the spread of HIV by reducing the individual and community level viral load. However, implementation of the 2013 WHO guidelines on provision of ART means the number of eligible PLHIV will increase, making sustainability of ART programmes in the Partner States a major challenge.

Avoiding TB deaths among PLHIV: Three EAC Partner States namely; Kenya, Uganda and Tanzania are among the 22 high-burden countries in the world which account for approximately 80% of all new TB cases arising each year. However, there has been considerable reduction and improvement in the situation between 2008 and 2011 with TB incidence in the three countries declining.

Gender and HIV response: Different sub-populations in the region continue to experience many forms of gender inequality and gender-based violence that predispose them to the risk of HIV infection. Nearly 20% of the women experience sexual violence although more than twice as many women have ever experienced physical and emotional spousal violence. There are legal, cultural and social barriers that affect access to HIV/AIDS services among some sub-populations.

Stigma and discrimination: There is an accepting attitude towards people living with HIV by the general population in the EAC Partner States. However, PLHIV in the region experience various forms of stigma and discrimination at the family and institutional levels. There are inadequacies in policy guidelines for facilitating offering ethical, non-stigmatizing and non-discriminatory services including those for HIV and AIDS.

Support for those affected by HIV and AIDS: Unlike in the pre-ART era, the region is experiencing a stabilization in the number of OVC partly because of the increase in the uptake of ARVs which prolongs the lives of PLHIV. Nevertheless, many extended and other families are overstretched with the burden of OVC, making it difficult for the social and economic needs (including educational and informal training needs) of the OVCs to be adequately addressed.

Financing HIV and AIDS response: Funding allocation for HIV and AIDS by EAC Partner States and development partners steadily increased before stagnating by 2012. In spite of the increased funding, the available funds cannot meet the respective Partner State needs and are also inadequate for sustaining the achievements attained to date in the regional response. There is therefore an urgent need for Partner States to (a) establish alternative financing mechanisms for HIV and other related and competing health priorities (b) improve on efficiency in resource utilization. The review has also noted that there is a gap in tracking resource allocation, utilization and reporting in the region.

Recommendations: The report presents recommendations for implementation at two levels, namely, EAC and Partner State levels:

EAC

1. Institutionalize the production of the EAC Regional HIV and AIDS Report every two years in harmony with other mandatory regional and global reporting.
2. Facilitate the process of harmonizing minimum standards for surveillance of HIV and AIDS issues and service delivery within the region
3. Facilitate the harmonization of national HIV and AIDS strategic plan development and timeframes to enhance monitoring and evaluation, ad for better comparison across Partner States
4. Strengthen the M&E system at the Secretariat in terms of structures and personnel to facilitate availability of high quality data for performance monitoring and reporting and linkage with the EAC Partner States
5. Enhance provision of combination prevention services among priority populations (including transport

corridor workers) through establishing a minimum package of services along the EAC transport corridors for key populations
6. Conduct social behavioral and survey studies on sub populations and dynamics in order to guide prioritization of programming and policy interventions
7. Develop a regional strategy for strengthening community systems to facilitate implementation of HIV and other health programs
8. Formulate a regional policy on local pharmaceutical manufacturing and pooled procurement of HIV commodities including ARVs in order to benefit from economies of scale
9. Work with Partner States to formulate a strategy for sustainable financing of HIV and health services based on the new approach on test and treat
10. Advocate and harmonize regional laws and policies that enhance access of HIV services without discrimination of marginalized populations

Partner States

1. Enhance the scale-up of high impact combination prevention interventions such as safe male circumcision, ART, PMTCT, condom promotion, treatment as prevention, targeting sub populations contributing highly to new infections in the region
    a. Strengthen mechanisms of ensuring universal access to services for pregnant women (ANC, eMTCT) and enhance scale-up of option B+ as a strategy for expanding efficacious treatment throughout the EAC Partner States
    b. Harmonize and roll out the most up to date WHO guidelines as a way of scaling up HIV treatment that is a main component of the regional response for addressing the epidemic
    c. Strengthen the supply chain system for drugs and other supplies supporting ART services

2. Strengthen linkages/integration across the continuum of response and services to promote uptake of combination prevention interventions
    a. Scale up integration of interventions against HIV stigma and discrimination in the comprehensive response to HIV and AIDS at family, community and institutional levels while also empowering PLHIV to live positively with the condition
    b. Strengthen the integration eMTCT into maternal, new born and child health services
    c. Increase screening for TB among HIV patients, provide PLHIV without active TB with isoniazid preventive therapy and put on ART all HIV/TB co-infected patients regardless of their CD4 count
    d. Create more awareness on TB especially among people involved in cross-border movements
    e. Strengthen diagnostics of TB among PLHIV and children through provision of sensitive diagnostic tools in health facilities such as GeneXpert

3. Strengthen management information systems and research to inform the policy and programming
    a. Continuously devise, revise and update indicators and tools for data collection (especially qualitative indicators)
    b. Update the mode of transmission studies
    c. Conduct behavioral and social dynamic studies to inform policy and programming

4. Review laws and policies that negatively impact on the national response to HIV e.g. those that criminalize commercial sex work and HIV transmission

5. Increase financing for HIV and AIDS and related health services in the different Partner States
    a. Employ strategies and interventions that sustainably, efficiently and effectively utilize and strengthen existing health structures and systems (e.g. improve staffing, lab, supply chain management, M&E systems) for enhancing delivery of integrated services in the region
    b. Increase local finance allocations through AIDS trust funds and public-private partnerships

c. Revitalize mainstreaming of HIV as a mandatory reporting and accounting requirement for approval of sectoral and local government plans

6. Promote strategies that (a) increase access to HIV and other health services, (b) empower priority populations (vulnerable and key populations) socially and economically
   a. Address social and structural factors that predispose some sub populations to HIV infection based on gender
   b. Target and engage young people in the implementation of HIV services (young positives, OVC, girls etc) in and out of school
   c. Accelerate provision of combination prevention interventions among priority populations

EAST AFRICAN COMMUNITY REGIONAL HIV AND AIDS RESPONSE REPORT 2013: REALISING THE REGIONAL GOALS IN HIV AND AIDS, TB AND STI PROGRAMMING

CHAPTER 1: INTRODUCTION

1.1 East African Community

The East African Community (EAC) is the regional intergovernmental organization of the Republics of Burundi, Kenya, Rwanda, United Republic of Tanzania and the Republic of Uganda, with its headquarters in Arusha, Tanzania. The objective of the Community is to widen and deepen economic, political, social and cultural integration in order to improve the quality of life of the people of East Africa through increased competitiveness, value added production, trade and investment. The Treaty for the Establishment of the East African Community was signed on November 30, 1999 and entered into force on July 7, 2000 following its ratification by the founding Partner States, namely, Kenya, Uganda and Tanzania.

1.2 Overview of the East African Community and its Socio-economic Situation

The East African region has a total surface area of 1,818 thousand square kilometers with Tanzania, Kenya, Uganda, Burundi and Rwanda accounting for 51.7%, 32.1%, 13.3%, 1.5% and 1.5% respectively (1). The region has a total land area of 1,716 thousand square kilometers as shown in the table below.

Table 1: Surface and Land Area ('000 Km2) of East Africa Partner States, 2012

STATE	AREA (Km^2)	
	Including water bodies	**Excluding water bodies**
Burundi	28	25
Kenya	583	581
Rwanda	26	24
Uganda	242	200
Tanzania	939	886
TOTAL	**1,818**	**1,716**

Source : EAC (2012)

The population projection in the EAC region was estimated by International Monetary Fund (IMF) (2) at 144 million persons in 2012. It was also projected that the population of the region would be over 155 million by 2015 (1). On the other hand, life expectancy in the region is lowest in Burundi (51 years) and highest in Rwanda (63 years).

Table 2: Population and Life Expectancy in East Africa Partner States

	POPULATION (million)		LIFE EXPECTANCY (years)
	2012	2015	2012
Burundi	8.8	9.4	50.9
Kenya	42.1	45.8	57.7
Rwanda	10.4	11.1	63.0
Uganda	35.6	39.3	54.5
Tanzania	47.1	50.0	58.9
TOTAL	144.0	155.6	-

Source: IMF (2013)

The economic prospects for the EAC Partner States look positive. In 2011, Rwanda had an economic growth rate of 8.6% followed by Tanzania and Uganda with 6.4 and 5.9% respectively. Growth rates were 4.4% for Kenya and 4.2% for Burundi. In terms of per capita income, the IMF (3) indicated that Kenya had the highest income at $833 while Burundi recorded the lowest at $274. In 2012 the pattern in gross domestic product per capita remained the same as that of 2011; a similar pattern was also projected for 2015 as is shown in the table below.

Table 3: Economic Development Indicators for EAC Partner States

	GROSS DOMESTIC PRODUCT PER CAPITA ($)			HUMAN DEVELOMENT INDEX	
	2011	2012	2015	2011	2012
Burundi	274.0	282.3	340.0	0.352	0.355
Kenya	832.5	976.5	1,268.5	0.515	0.519
Rwanda	624.3	693.0	833.2	0.429	0.434
Uganda	510.4	589.2	626.0	0.454	0.456
Tanzania	516.0	599.2	749.3	0.470	0.476

Source: IMF (2013)

The Human Development Index (HDI)1 for the EAC Partner States remained low except for Kenya which was at over 0.5 HDI. There was, however, some improvement between 2011 and 2012 in the HDI across the Partner States.

1.3 Development of the EAC Regional HIV and AIDS Response Report

Purpose of the report: The purpose of this report is (a) to discuss the current status, trends and response to the HIV and AIDS epidemic in the Partner States and the region as a whole in the context of national and international goals (b) to generate evidence which will form a basis for re-programming the EAC response to the HIV and AIDS epidemic towards an early achievement of zero new infections, zero AIDS deaths and zero stigma and discrimination (c) to provide information to support advocacy and resource mobilization efforts for EAC (d) to identify issues that require review/harmonization of existing policies or formulation of new policies, laws and programmes necessary in the implementation of the regional HIV and AIDS response. It is envisaged that a similar report will be produced in the future for informing regional policy, programming and decision making.

Methodology used in developing the report: A participatory approach was used in writing this report facilitated by a consultant. An Inception Report on the work was presented by the consultant and discussed by the EAC Monitoring and Evaluation (M&E) Technical Working Group (TWG) in Kigali, Rwanda. Thereafter, documents from the EAC Secretariat, Partner States, regional bodies, UNAIDS and other UN agencies, internet and other sources were assembled and reviewed by the consultant in order to collect information on global and regional responses to the epidemic, achievements and challenges experienced during the implementation by the EAC and Partner States. Epidemic estimates on the current status and recent trends in the epidemics in this region were provided by UNAIDS. The key documents used in this report included (a) HIV and AIDS strategic plans, (b) AIDS Indicator Survey (c) Demographic and Health Survey (d) Mid-term Review of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS (e) UNAIDS reports on Global AIDS Epidemic, (f) Mode of Transmission studies (g) Global Tuberculosis (h) Progress on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, (i) nationally commissioned studies on HIV and AIDS e.g. National Stigma Index studies (j) National AIDS Spending Assessment and (k) Global AIDS Response Progress Report (GARPR) – Country Progress reports. The information collected was analyzed and a draft report produced and shared with the EAC M&E sub group in a workshop whose participants included (i) M&E officers and HIV and AIDS technical experts from Partner States (ii) representatives from UNAIDS, USAID and SIDA. A revised report was further reviewed during a consultation workshop organized in each Partner State. This report was finally reviewed by independent peer reviewers from the five Partner States to validate its findings.

Challenges and limitations of the report: The major limitation of the report is that it uses mainly population-based data and less of programme and primary data from key stakeholders. For instance, although 2013 was coming to an end

1 Human Development Index (HDI): A composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, knowledge and a decent standard of living.

when the writing of the report started, it was agreed that the report should only cover 2012 because (a) there were no estimates of the HIV epidemic from the spectrum models for 2013 (b) national level programme information for 2013 was only being compiled by respective countries and hence needed to be given time for consensus building. The other challenge was that complete, consistent and comparable programme and population-based survey data could not be obtained in some cases for all the countries. Thus, in some cases information from Demographic and Health Survey is tabulated or used alongside those from AIDS Indicator Surveys. In other cases, in some Partner States, there were studies carried out but their reports were not yet available by the time this report was drafted and reviewed. Lastly, the documents and reports from Burundi were in French which took considerable time to have them translated.

Report structure: This report is structured along eleven chapters including the introductory chapter. Chapter 2 presents an overview of the global and East African Community regional HIV and AID situation while Chapter 3 discusses the regional responses to the epidemic. The subsequent Chapters 4 and 5 discuss efforts on elimination of new infections in the general population and among children respectively. Chapter 6 addresses the provision of treatment to people living with HIV while Chapter 7 tackles the issue of tuberculosis in the region. While Chapter 8 discusses gender and HIV and AIDS, Chapter 9 deals with stigma and discrimination. Chapter 10 discusses support for families and children affected by HIV and AIDS, and the last chapter presents issues related to current and future funding of the HIV and AIDS response in the region.

CHAPTER 2: OVERVIEW OF HIV AND AIDS SITUATION IN EAST AFRICA

The world today is witnessing the fourth decade of the existence of the HIV and AIDS epidemic.Globally, there is commitment for progressively moving to a world in which there are zero new infections, zero AIDS deaths and zero discrimination on account of being infected/affected by HIV and AIDS. This chapter presents a global overview of the epidemic in order to provide the context in which the epidemic in the East African Community occurs. The socio-economic situation in the five Partner States is then highlighted before information is provided on HIV prevalence, new infections and AIDS deaths in the region.

2.1 Global HIV Epidemic

The epidemic is prevalent in all the countries in the world, some having a generalized epidemic while other countries have epidemics that are concentrated2 among key populations or have epidemics that are both generalized and concentrated. The epidemic continues to significantly impact different aspects of human life including local, regional and global economies.

2.1.1 Prevalence of HIV

By the end of 2012, UNAIDS (1) estimated that there were 35.3 million (32.2 – 38.8 million) people living with HIV (PLHIV) worldwide. Ninety one percent of the people living with HIV in 2012 were adults, with 50% of these being women and 50% men; the 3.3 million infected children under 15 years constituted 9% of the PLHIV in the year.

Globally, the burden of the epidemic varies considerably across the regions. Sub-Saharan Africa accounts for about 70% of people living with HIV. Eastern and southern Africa alone account for just over 50% of the global HIV burden.

2.1.2 New HIV Infections

The number of new HIV infections has fallen by 32% between 2001 and 2012 from 3.4 million to 2.3 million. While the decline in the global number of new infections is significant, the absolute number of new infections in 2012 was still unacceptably high. The number of new HIV infections among adults and adolescents decreased by 50% or more in 26 countries and between 25% and 49% in 17 countries between 2001 and 2012. Among children, new HIV infections declined by 52% between 2001 and 2012 because of the significant scale-up of services to prevent mother-to-child transmission. In 2012, 260,000 children became newly infected with HIV, down from 550 000 in 2001 (1).

UNAIDS also estimated that Sub-Saharan Africa accounted for about 70% of all new infections in 2012.

2.1.3 Deaths due to AIDS-related Illnesses

AIDS-related deaths have continued to fall across the world. In 2012, 1.6 million people died from AIDS-related causes globally compared to 2.3 million in 2005 when it reached a peak, representing a fall of 30% (1). The reduction in deaths due to AIDS-related conditions is mainly due to the large scale-up of antiretroviral treatment that is helping to save the lives of people living with HIV. In 2012, 9.7 million people living with HIV in low and middle-income countries were receiving life-saving antiretroviral therapy (ART), representing a coverage of 61% of people eligible for treatment according to the 2010 WHO guidelines(2) and 34% of people eligible under the 2013 WHO guidelines (3).

UNAIDS (1) estimated that three of every four AIDS-related deaths in 2012 occurred in Sub-Saharan Africa , while it was also estimated that during the period 2001 and 2012 there was a 22% reduction in the number of AIDS-related deaths in this region.

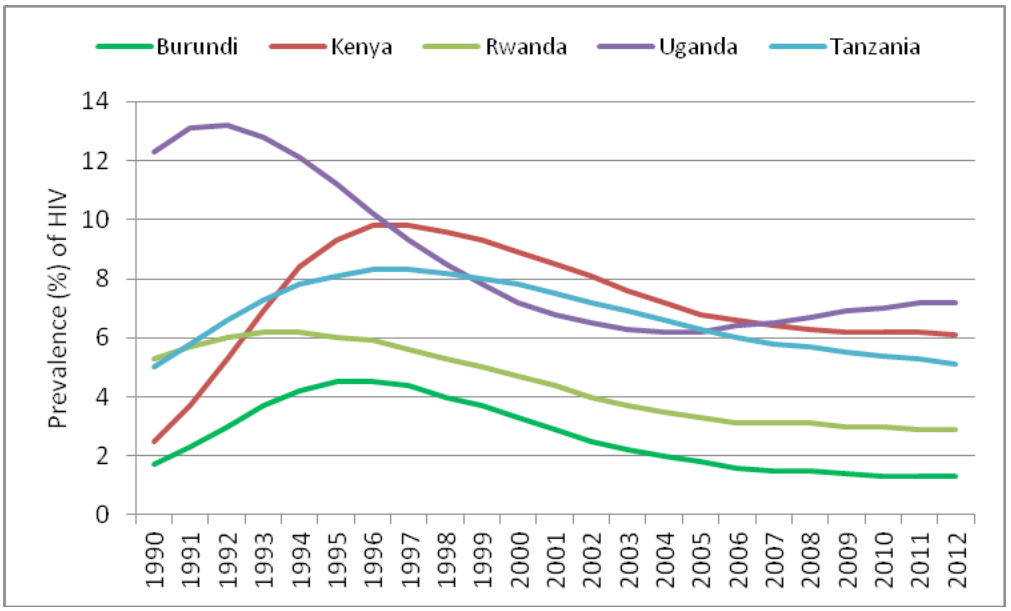
2 HIV has spread rapidly in one or more populations most at risk for HIV infection as a result of high-risk behavior but in the general population the epidemic is not yet well established.

2.2 Situation of HIV and AIDS in the East African Community

2.2.1 HIV prevalence in East Africa

According to the UNAIDS (1) report, 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. These levels were the lowest ever for Burundi, Kenya and Rwanda since the 1990s. For Uganda the prevalence was similar to the situation in 2000 while for Tanzania it was similar to that observed in 1991 (Figure 1). HIV prevalence had peaked at around 5% between 1995 and 1997 in Burundi, at 10% between 1996 and 1998 in Kenya, at 6% in Rwanda between 1990 and 1994 and at 8% in Tanzania between 1994 and 1998. Since that time there has been a consistent downward trend in prevalence for these four Partner States. For Uganda, the epidemic had been at its worst in the late 1980's where prevalence was as high as 18% among adults. It then showed a decline throughout the 1990s but prevalence started to increase again since around 2004.

Figure 1: Trend in HIV Prevalence in EAC Partner States, 1990-2012



Source: UNAIDS Report on the Global AIDS Epidemic - 2013

UNAIDS (1) estimated that in 2012 there were 5 million (4.6 – 5.3 million) people living with HIV in the region. Kenya, Uganda and Tanzania each contributed one third of the PLHIV in the region. Between 2001 and 2012 there was an overall percentage decline (32%) in both the number of adults and children living with HIV in Burundi and Rwanda, while in Uganda, there was a considerable increase (69%) in the number of adults living with HIV but a substantial decline among children living with HIV (41%). In Tanzania, there was a decline of 8% from 1.3 million to 1.2 million of adults living with HIV and an increase of 50% from 200,000 to 300,000 among children living with HIV (Table 4). It should be noted that in the EAC region, women have a greater burden of HIV and AIDS than men (as discussed in Chapter 8 of this report).

Table 4: Adults and Children Living with HIV, 2001 and 2012 in EAC Partner States

Partner State	Adults		Children		ALL	
	2001	2012	2001	2012	2001	2012
Burundi	100,000	72,000	30,000	17,000	130,000	89,000
Kenya	1,400,000	1,400,000	200,000	200,000	1,600,000	1,600,000
Rwanda	200,000	180,000	40,000	30,000	240,000	210,000
Uganda	830,000	1,400,000	170,000	100,000	1,000,000	1,500,000
Tanzania	1,300,000	1,200,000	200,000	300,000	1,500,000	1,500,000
TOTAL	3,830,000	4,252,000	640,000	647,000	4,470,000	4,899,000

Source: UNAIDS(2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

2.2.2 New HIV infection in Eastern Africa

There was a reduction in the number of people who were newly infected with HIV in the EAC from 390,000 to 330,000, representing a decrease of 14% between 2001 and 2012 (1). During the same period, there was a consistent decline in the number of new infections among adults and children in Kenya, Rwanda and Tanzania. However, an increase in new infections among adults in Burundi (65%) and Uganda (74%) was observed, as shown in Table 5.

Table 5: Number of New Infections among Children and Adults

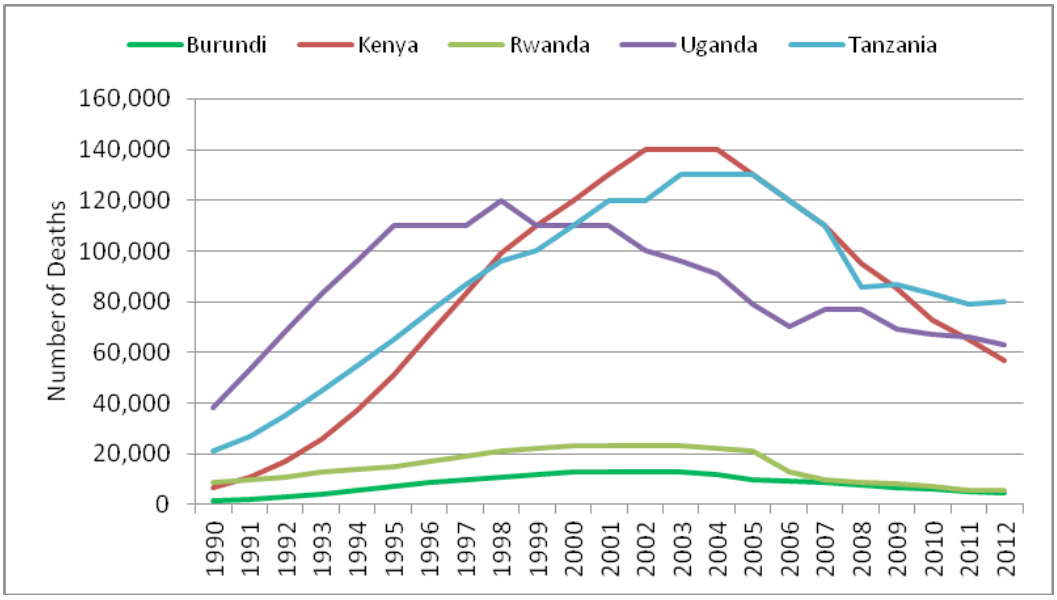
Partner State	Adults		Children		ALL	
	2001	2012	2001	2012	2001	2012
Burundi	2,000	3,300	3,600	1,300	5,600	**4,600**
Kenya	97,000	85,000	43,000	13,000	140,000	**98,000**
Rwanda	11,000	6,900	6,000	900	17,000	**7,800**
Uganda	69,000	120,000	25,000	20,000	94,000	**140,000**
Tanzania	91,000	69,000	39,000	14,000	130,000	**83,000**
TOTAL	270,000	284,200	116,600	49,200	386,600	**333,400**

Source: UNAIDS (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

2.2.3 AIDS Deaths in Eastern Africa

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 2). 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 (1).

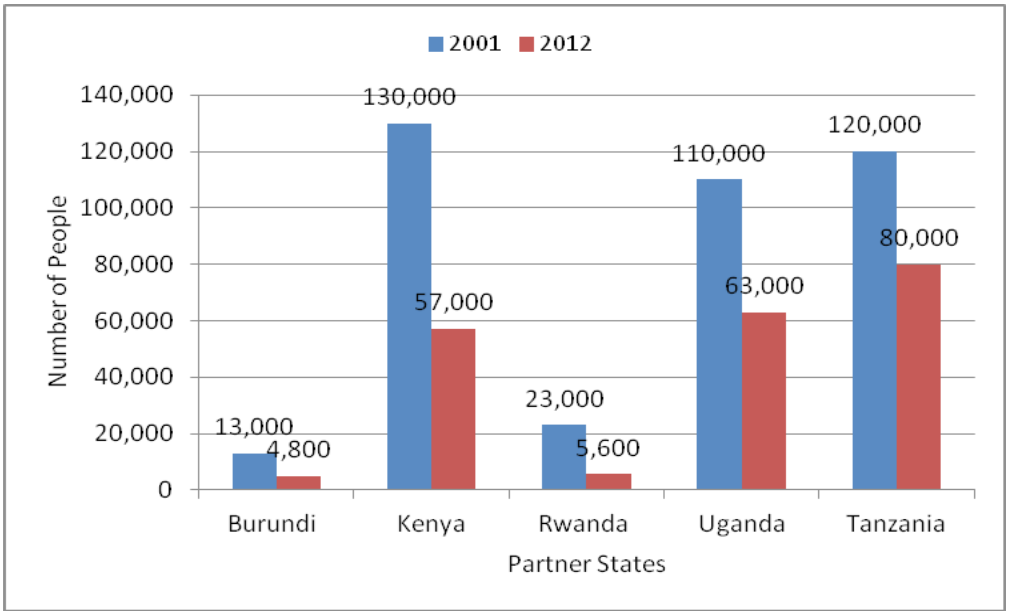
Figure 2: Trend in AIDS-related Deaths in EAC Partner States, 1990-2012



Source: UNAIDS Report on the Global AIDS Epidemic - 2013

The significant decline in the number of AIDS-related deaths is associated to the massive scale-up of ART availability, access and uptake since 2005. Thus, less than half the deaths recorded in 2001 were estimated to have occurred in 2012 for Burundi (37%), Kenya (43%) and Rwanda (24%) although the PLHIV that died in 2012 were more than half the number in 2001 for Uganda (67%) and Tanzania (53%) as illustrated in the Figure 3 below.

Figure 3: Deaths related to AIDS in EAC Partner States, 2001 and 2012



Source: UNAIDS (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

2.4 Summary on State of the Epidemic in the East African Community

The review has found that;

a. There has been a general decline in the trend of HIV prevalence since the 1990s. In 2012, it was estimated that it reached 1.3% in Burundi, 6.1% in Kenya, 2.9% in Rwanda, 7.2% in Uganda and 5.1% in Tanzania.
b. The number of people living with HIV remains high at 4.9 million in 2012 compared to 4.5 million in 2001.
c. New infections per year have gone down from 390,000 to 330,000, representing a decline of 14% between 2001 and 2012.
d. There has been significant decline in the number of AIDS-related deaths due to the sustained increase in the scaling up of ART availability, access and uptake in the region, from 188,000 in 2005 to more than 1.6 million in 2012.

CHAPTER 3: THE REGIONAL RESPONSE TO THE HIV EPIDEMIC

In the 1990s when the HIV and AIDS epidemic was spreading from a localized to a generalized epidemic in the various countries of East Africa, the Partner States adopted a multi-sectoral AIDS Control approach which was rationalized into national policy and strategic documents. In this chapter, the policy framework for the national and regional response to epidemic is presented followed by a presentation on the strategies used by the individual countries and the East African Community in 2012 and 2013.

3.1 Policy Framework

As early as the late 1980s, **Uganda** was one of the first countries in Africa to recognize the significance and dangerous implications of the HIV and AIDS epidemic. Thus, despite limited evidence on how to control the HIV epidemic, the country spearheaded the establishment of the first supra-ministerial body in Africa to coordinate the response. Accordingly, Uganda AIDS Commission (UAC) was established as a corporate body for the prevention and control of AIDS in 1992 through an Act of Parliament (1). The key functions of the UAC were to include planning and coordination of all AIDS control policies and programmes within the overall national response; identifying obstacles to AIDS control policy and programme implementation; ensuring implementation and attainment of programme activities and targets; mobilizing, expediting, and monitoring resources for the AIDS control programme activities; and disseminating information on the AIDS epidemic and its consequences in Uganda. UAC is under the President's Office.

In **Burundi,** the Decree no 100/15 was amended to, among other things, establish an institutional framework for coordinating and overseeing the implementation of the national response to HIV epidemic in the country. In the framework there are two key structures, namely, National AIDS Council (NAC) and the Presidential Ministry in charge of AIDS Control (PMAC). The NAC is chaired by the President of the Republic and has a Permanent Executive Secretariat PES/NAC with autonomous management (2). The PMAC chairs the Executive Committee and the administrative ruling of the PES/NAC by delegation of the President of the Republic. The PES/NAC is the technical organ of NAC that is responsible for the implementation of the national strategic plan. Each ministry is considered as a sector and therefore has a sector unit in charge of AIDS control with a focal point person that is responsible for ensuring the implementation of the sector action plan.

In **Kenya,** HIV and AIDS was declared a national disaster in 1999 after which the Government established the National AIDS Control Council (NACC) through a Presidential Legal notice No 170 of 1999 (3). The NACC is in the Ministry of Health. On the other hand, in Tanzania, through an Act of Parliament in 2001 and an Act of House of Representatives in 2002, a National Policy on HIV and AIDS was passed; it provided for the establishment of the Tanzania Commission for AIDS (TACAIDS) in the Prime Minister's Office (PMO) and Zanzibar AIDS Commission, which is under the First Vice President's Office to coordinate and operationalise the multi-sector response to HIV and AIDS Epidemic in the country (4). Thus, it emphasized the need for strong political commitment and leadership from all levels of government and civil society to ensure sustained and effective interventions.

In the **East African Community** as a whole, the Partner States decided to take joint action towards the prevention and control of communicable diseases with epidemic and pandemic potential such as HIV and AIDS (5). This was concretized in 2012 when the EAC HIV and AIDS Prevention and Management Bill was enacted by the East African Legislative Assembly (EALA). Noting that HIV and AIDS would adversely affect the intended widening and deepening of economic, political, social and cultural integrations necessary for improving the quality of life of the people in the region, EALA passed this law to provide for the prevention and management of HIV and AIDS and for the promotion of human rights of persons living with or affected by HIV and AIDS and for related matters within the region. The Bill is being accented to by Partner States.

3.2 Strategic Approach

Burundi reviewed the National Strategic Plan on HIV/AIDS Control 2007-2011 (2) and developed a new strategic plan 2012-2016 for HIV and AIDS control (6). The plan has four strategic lines. Strategic Line 1 is on reducing the STI/HIV transmission through the increase and the extension of prevention activities deemed effective while Strategic Line 2 is on improvement of PLHIV well-being and quality of life. Poverty reduction and other HIV vulnerability influencing factors are captured under Strategic Line 3 while Strategic Line 4 deals with Improvement of the management and the coordination of the National Policy on HIV/AIDS. .

The **Kenya** National HIV and AIDS Strategic Plan III (KNASP III) 2009/10–2012/13 is the third strategic development plan (3) for the response to HIV epidemic; it was preceded by the second Kenya National HIV and AIDS Strategic Plan 2005/6-2009/10. KNASP-III3 is implemented under four pillars, namely, Health Sector HIV Service Delivery, Sectoral Mainstreaming of HIV, Community-based HIV Programmes, and Governance and Strategic Information. The goal of pillar 1 is to achieve universal access targets for an integrated, prioritized package of prevention, treatment, care and support services by 2013. Under Pillar 2, the goal is to achieve comprehensive integration of HIV prevention, treatment and socio-economic protection interventions in all areas of the public and private sectors, as well as civil society, in a harmonized and aligned manner. The goal of Pillar 3 is to strengthen community capacity towards achieving Universal Access and social transformation for an AIDS-competent society. Lastly, under Pillar 4, the goal is to create an enabling environment for implementation of all pillars through strengthened policy, leadership, oversight, partnership, and governance at national and decentralized levels.

The National Strategic Plan 2009-2012 on HIV and AIDS (NSP) for **Rwanda** (7) followed a previous one that covered the period 2005-2009. The 2009-2012 strategic plan has three goals or impact areas, namely, the incidence of HIV in the general population is halved by 2012; morbidity and mortality among people living with HIV are reduced; and people infected and affected by HIV have the same opportunities as the general population. Under the first impact area, the outcomes expected include (a) reduction of sexual transmission of HIV (b) reduction of vertical (mother to child) transmission of HIV (c) maintenance of low levels of blood-borne transmission of HIV. The second impact area was to be achieved when the following three outcomes are realized - people living with HIV systematically receive opportunistic infection prophylaxis, treatment and other co-infection treatment according to national guidelines; all people living with HIV eligible for ART receive it; and PLHIV receive care and support according to needs. The last impact area has three important outcomes, namely, people infected and affected by HIV (including child-headed households and widows) have improved economic opportunities and social protection; social and economic protection are ensured for orphans and vulnerable children; and reduction of stigma and discrimination of PLHIV and OVC in the community.

Uganda is currently implementing National Strategic Plan 2011/12-2014/15 (8) that was developed following the implementation of a previous one that was to cover the period 2007/08-2011/12. This on-going NSP has four thematic areas, namely, prevention, care and treatment, social support and protection and systems strengthening. The goal of the prevention thematic are is to reduce HIV incidence by 30% by 2015 while that for care and treatment is to improve the quality of life of PLHIV by mitigating the health effects of HIV and AIDS by 2015. The NSP identified that the goal of social support and protection thematic area is to improve the the level of access to services for PLHIV, OVC and other vulnerable populations by 2015. Lastly, in systems strengthening, the goal is to build an effective and efficient system that ensures quality, equitable and timely service delivery by 2015.

In **Tanzania,** the second National Multi-sectoral Strategic Framework (NMSF) on HIV and AIDS 2008-2012 (9) and Zanzibar National HIV&AIDS Strategic Plan (ZNSP) 2011-2016 (10) were built on the achievements and strengths of the first NMSF that covered the 2003 – 2007 and ZNSP I (2004 – 2009). The NMSF provides strategic guidance in the national response and has eight goals, namely, to create a political, social, economic and cultural environment for the national response to HIV reduce the HIV transmission reduce morbidity and mortality due to HIV and AIDS

3 An End of Term Review of this Strategic Plan has just been completed; and development of the next strategic framework entitled "Kenya HIV and AIDS Strategic Framework" for the period 2014/15 to 2018/19 (KASF) is ongoing and is expected to be completed by October 2014. The strategy takes into account the devolved system of government under the Constitution of 2010

improve the quality of life of PLHIV and those affected by HIV and AIDS, use relevant and comprehensive evidence provided in HIV-related planning and decision-making provide well-coordinated, effective, transparent, accountable and sustainable leadership and management structures provide financial, human and technical resources for the implementation of the national response to HIV and translate the NMSF into well-defined operational plans at national and local government authority levels.

In **Zanzibar** where there is a concentrated HIV epidemic, ZNSP has five strategic priority areas, namely, prevention of new infections; treatment, care and support of the PLHIV; mitigation of socio-economic impact of the epidemic; creation of an enabling environment; and research, monitoring and evaluation. The concentrated epidemic is largely driven by MARPs that is constituted by the following key populations, injecting drug users (IDUs), female sex workers (FSWs), students in the Institute of Education for Offenders (correctional facilities), and men having sex with men (MSMs).

Regarding the regional response, the first **EAC** HIV and AIDS Multisectoral Strategic Plan 2008 – 2013 focused on: mainstreaming HIV and AIDS into the Organs and Institutions of the EAC; improving the effectiveness of interventions through the harmonization of EAC Partner States' HIV and AIDS protocols, policies, plans, strategies, and legislation; easy access to strategic information and knowledge on the epidemic; strengthening of political leadership and commitment towards addressing the epidemic; and, consolidating effective partnerships among strategic partners both within and outside the EAC region in response to HIV and AIDS among others. The strategic plan was revised and realigned for the period 2012-2014 (11). This Realigned EAC HIV and AIDS Strategic Plan (2012-14) has four main strategic objectives, namely, (a) To scale up regional and national leadership involvement, commitment and ownership for sustainability of HIV and AIDS response; (b) To facilitate the adoption, harmonization and implementation of international and regional protocols, guideline, policies and strategies; (c) To improve the designing, management, and sustainability of HIV responses at national and regional level; and (d) To strengthen the coordination and implementation of regional responses for mobile and key populations in the EAC region.

3.3 Coordination Framework

In **Burundi,** PES/NAC is the technical arm for coordination of the implementation of the strategic plan. PES/NAC also works in partnership with CSOs, religious organizations and private sector agencies with activities on HIV/AIDS. In addition to PES/NAC, there are other structures at lower levels whose key role is to coordinate the decentralized policy implementation at their respective levels. This includes (a) the Sectoral Units on AIDS Control (SUAC) in the different ministries and other national institutions (b) the Provincial Committees on AIDS Control (PCAC), (c) Communal Committees on AIDS Control (CCAC) and (d) Local Committees on AIDS Control (LCAC). Against this background, it is pertinent to note that Ministry of Public Health and Fight Against HIV holds control over all health structures and activities in the sector (6).

In **Kenya,** the multi-stakeholder NACC Board has a Secretariat that coordinates the implementation of the national Strategic Plan4. The Secretariat with the support of the Inter-agency Coordinating Committee (ICC) that is a partnership forum for all stakeholders in the sector and the ICC Advisory Committee, coordinates all key multi-sectoral actors implementing the strategic Plan. In addition to this, however, there are specific structures for coordinating each pillar of the NSP. Pillar 1 is coordinated by National Health Sector HIV Coordination Forum while Pillar 2 is coordinated by the National Sectoral Mainstreaming of HIV Committee. The National Community Coordination Forum and the Governance and Strategic Information Coordination Committee provide platforms for coordination of stakeholders under Pillars 3 and 4 respectively (3).

In **Rwanda**, coordination of the national response was rationalized in 2006 when PNLS (National Program for the Fight against AIDS) was restructured into the National AIDS Commission (CNLS) and the Treatment and Research AIDS Centre Plus (TRAC Plus) coordinating clinical activities in HIV response. CNLS had an Executive Secretariat, responsible for coordinating the National Multi-sectoral HIV and AIDS Strategic Plan. On the other hand, the District AIDS Control

4 With the completion of KASF a new coordination framework will be established that takes into account the new governance system

Committees (CDLS) were established to support district mayors in managing the HIV and AIDS response and to coordinate the district-level HIV response across implementing partners. It consists of representatives of decentralized public services (health, education, planning), of mass organizations (national women and youth councils) and of civil society organizations (PLHIV, NGO, FBO networks as well as people living with disabilities (PWD) in some districts) and it works closely with the CNLS (7, 12).

In January 2011, however, **Rwanda** Biomedical Center (RBC) was created by merging CNLS, TRAC Plus and others institutions coordinating the response of others diseases by the law no 54/2010 with the mission to promote quality affordable and sustainable health care services to the population through innovative and evidence-based interventions and practices guided by ethics and professionalism. Thus, at RBC now, the HIV and AIDS, STIS and Other Blood Borne Infection Division is the national coordinating agency responsible for ensuring that all HIV interventions in Rwanda are harmonized and aligned with national priorities and strategies, in keeping with the three Ones principles (one national coordinating body, one national strategy, one national M&E framework). It is responsible for (a) national planning, formulation of policies, training of trainers, and the development of the curricula for clinical programs (b) technical assistance and guidelines in the organization and effective management of HIV and AIDS, STI, other blood borne infection control programs (c) monitoring, evaluating and coordinating health sector activities as a whole in response to HIV (d) coordination of research on STI, OI, VCT/PMTCT, TB and ART, as well as socio-behavioral research. Other divisions within RBC that play important roles in the national HIV response include National Reference Laboratory (NRL) Division, National Center for Blood Transfusion (NCBT), Health Communication Center (HCC), Medical Procurement and Production Division (MPPD), Tuberculosis and Other Respiratory Diseases Division (TB) and Vaccine-Preventable Diseases Division (VPD).

The Uganda AIDS Commission **(UAC)** established the multi-sectoral HIV and AIDS Partnership in 2002 (1) to provide an opportunity for all stakeholders to participate in the coordination of the national response. The Partnership to which UAC provides the secretariat has four components, namely, Self-coordinating entities, Partnership Committee, Partnership Fund and Partnership Forum. A Self-Coordinating Entity is a constituency of actors working in the same thematic area; to-date SCEs are 12, namely,: decentralized levels of government; faith based organizations (FBOs); government ministries; international NGOs; media, arts and culture; national NGOs; networks of people living with HIV and AIDS; Parliament; private sector organizations; research institutions and academia; United Nations and bilateral development group; and young people. HIV and AIDS Partnership Committee which is also the Steering Committee for NSP includes representation of Ministries/Sectors, Self-Coordinating Entities, and donor partners; it works through sub-committees and technical working groups such as M&E, Information and Advocacy, Prevention and Resources Management. The HIV and AIDS Partnership Forum – meets annually and includes government officials and all partners of SCEs; it provides an opportunity for wider representation by all constituencies to review the response and agree on annual priorities. The HIV and AIDS Partnership Fund is a jointly managed fund covering coordination costs of the Uganda HIV and AIDS Partnership and assisting the UAC in coordinating the national multi-sectoral response; it is supported by the AIDS Development Partners. At the sub-national level, there are the District AIDS committees (DACs), PLHIV district networks and NGO forum that have been established at the various local government levels. These are responsible for coordination of stakeholders and overseeing the planning, implementation and monitoring of the national response by the respective local governments.

In **Tanzania**, TACAIDS (9)) and ZAC (10) are supported by a secretariat in the coordination of the implementation of the strategic plan. However, in the sectors, all Ministries, Departments and Agencies (MDAs) have their own structures for coordinating their response. The key ministries include Ministry of Health and Social Welfare; Ministry of Education and Vocational Training; Ministry of Agriculture, Food Security and Cooperatives; Ministry of Water; Ministry of Community Development, Gender and Children; Ministry of Labour, Employment and Youth Development; Ministry of Defense and National Service; Ministry of Justice; and the Prime Minister's Office Regional Administration and Local Government. At the local government level, Village Multi-sectoral AIDS Committees (VMACs), Ward Multi-sectoral AIDS Committees (WMACs), Council Multi-sectoral AIDS Committees (CMACs), Council HIV and AIDS Coordinators (CHACs), District AIDS Coordinators (DACs) and the council and district commissioners and district consultative committees are important mechanisms to coordinate, plan and deliver the HIV programmes. On the other hand, the Government of Tanzania

has also put in place the Tanzania National Coordinating Mechanism (TNCM) as a multi-sectoral forum for sharing information and coordination of resources within Tanzania from various sources for HIV, TB and Malaria, and any other health related emergency. TACAIDS serves as the secretariat for the TNCM.

In **Zanzibar**, the Office of the First Vice President is responsible for the overall governance of national response through the Zanzibar AIDS Commission (ZAC). ZAC coordinates the national response to the HIV epidemic under the guidance of the Board of Commissioners. On the other hand, the Zanzibar's Ministry of Health oversees the implementation of the plan while the Zanzibar AIDS Control Program (ZACP) supports actual implementation of the plan.

The coordination of the **EAC** HIV response is through the HIV and AIDS Steering Committee and the HIV and AIDS Technical Committee with the support of the EAC Partner States' NAC Secretariats. The secretariat for these coordination functions is provided by the EAC HIV and AIDS Unit whose overall mandate is to coordinate and oversee the HIV and AIDS response in the region. On the other hand, implementation of HIV and AIDS interventions at regional level has been done by both the EAC HIV and AIDS Unit, and the EALP programme coordinated by Lake Victoria Basin Commission (LVBC) Secretariat in Kisumu.

In general, the mechanisms adopted by Partner States vary because, among others, because of the diversity in socio-economic circumstances of the population as well as the capacities and methods of work of the numerous implementers in the individual countries.

3.4 Monitoring and Evaluation

Monitoring and evaluation is a cornerstone of strategic planning. It provides the basis for assessing results against desired levels of performance.

In Burundi, the monitoring and evaluation information system is a key priority in the national response (2). The system is computerized and is continuously fed with data using the AIDS-INFO software for data and information management. The M&E national plan and data collection tools are available for facilitating data flow from the CSOs and other implementing agencies that are connected to the CCAC and PCAC that collect data and information for delivery to PES/NAC. SUAC directly report to PES/NAC.

Kenya has the KNASP III Oversight and Performance Monitoring Committee that is comprised of all Pillar Conveners and selected key senior pillar implementers/partners (3). The committee meets quarterly under the chairmanship of NACC to review achievements, address capacity gaps, share information, and plan future work. In addition to this, however, there is the National HIV M&E Committee whose role is to coordinate implementation and review of the Monitoring, Evaluation and Research Framework and Plan to support the implementation of the Strategic Plan, and reporting to all stakeholders.

The strategic plan provides for a joint annul performance review for assessing progress against the KNASP III Results Framework, revisiting the National Plan of Operations for each pillar, assessing overall resource needs, addressing implementation challenges (including an action plan to overcome them) and identify priorities for the coming year. Besides, a KNASP III Mid-term Review and End of KNASP III Review have also been provided for during the period of KNASP-III implementation.

In Rwanda, NSP has an associated HIV M&E Framework that has both health facility-based and community-based components at district and national levels (7,12). The health facility-based components of the HIV M&E system are integrated and mainstreamed into the existing Health Sector M&E system and Health Management Information System (HMIS) and TRACnet while the HIV is integrated and mainstreamed into the existing M&E systems for the other sectors. A national HIV and AIDS M&E Technical Working Group (TWG) composed of M&E experts from government sector representatives, UN agencies, multilateral and bilateral agencies, civil society umbrella organizations and other key NGOs, the private sector, academic and research experts involved in the community-based M&E system has been

established to work with the district-level HIV M&E stakeholders for enhancing linkages and synergy between the national and decentralized levels for M&E.

In Uganda, The national M&E system for the HIV and AIDS response has a framework that outlines national results, indicators and targets under each thematic area and objectives (13). Thus, the M&E Framework has been developed to enable monitoring and self-assessment of progress towards results and facilitate reporting on performance. To support this process, there is the National Monitoring and Evaluation Technical Working Group composed of experts from government sectors, SCEs and the donor community among others. The M& E data is captured from the different implementation levels (districts and partners) through the line ministries (e.g. MOH, MOGLSD, MOES, MAAIF, etc). The national database at UAC under the NADIC was designed to capture information from the different line ministries. The database is still under development. .

Under the leadership of UAC, the M&E Framework provides for an annual Joint AIDS Review (JAR) to assess progress of implementation of the NSP and National Priority Action Plan (NPAP) against targets and agree on priorities for the upcoming year. The JAR assesses the outputs/outcomes of each year as a key accountability mechanism to assess the implementation of the NSP/NPAP; it also assesses the planning and programming process, in time to make recommendations for the next annual work planning cycle or long term strategic planning. In addition to the JAR, HIV stakeholders also hold an annual Partnership Forum (PF) to provide opportunity for wider representation by all constituencies to review performance of the response and agree on priorities for the upcoming year.

The implementation of the revised NSP will be externally evaluated at mid-term and a final external evaluation will be conducted at the end of the revised NSP period (mid 2015), in time for the results to feed into the planning process for the next NSP.

Tanzania: TACAIDS and ZAC developed an M&E system (4) for the national response with the health and non-health system components. The non-health component is operationalized through the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) and Zanzibar HIV&AIDS Programme Monitoring System (ZHAPMoS) and Education Management Information System (EMIS), while the health monitoring and evaluation is through Health Management Information System (HMIS) integrating Care and Treatment (CTC) database. The routine systems are complemented by population-based data collection measures such as ANC surveillance and AIDS indicator surveys. Coordination of M&E activities is a major task of the TACAIDS M&E Directorate and ZAC Policy and Planning Division, which also bears the responsibility of providing a strategic oversight of M&E needs, activities, identifies gaps and new initiatives across the various sectors. The M&E system also provides for M&E Leadership and Coordination Stakeholder Forum meetings, including TWG for Monitoring Evaluation and Research, Annual Performance Reporting and Joint Annual Performance Reviews. In addition to this, the strategic plan indicates that halfway through the NMSF and ZNSP II, a midterm review will be undertaken. This Midterm Review of NMSF has been conducted at the start of 2010, and that for ZNSP II has been scheduled to take place in February 2014. This activity is aimed at reviewing the progress, achievements and challenges of the National Response. At the end of the NMSF and ZNSP II period, a final evaluation will be conducted to assess overall achievement of NMSF objectives, to assess the major challenges to achieving NMSF objectives and to provide the basis for developing the new NMSF and ZNSP respectively.

In the regional response, the HIV and AIDS Unit is supported by an M&E Technical Working Group. The membership of this TWG consists of M&E experts from the national AIDS councils and representatives from Ministries of Health. The chair and meetings of the TWG rotate among the Partner States.

In 2010, the LVBC with support from the EAC HIV Unit carried out the HIV Sero-behavioral studies among plantation workers, university students and fisherfolk in the Republic of Uganda, Republic of Kenya and the United Republic of Tanzania. The results from the studies were packaged into policy briefs (14,15,16,17,18,19,20,21,22) that were adopted by the Partner States and have been used to guide programming and policy in the Partner States.

Although there are respective M&E systems to support the implementation of the NSP, there is no clear relationship and guide between (a) EAC M&E and country M&E groups and (b) African Union and EAC formats of reporting. Through modeling, the Partner States have been able to generate estimates on key parameters of the epidemic on an annual basis. However, data sources for actual counts of new infections and death and their causes through surveillance systems is weak. Furthermore, while data quality differs among the countries due to different levels of performance of their M&E systems, the use of the International Classifications of Diseases (ICD 10) by health facilities is also low.

3.5 Summary on Regional Response to HIV Epidemic

EAC Partner States have adopted a multi-sectoral approach in response to the epidemic. Each Partner State has (a) a National AIDS Council that has been put in place by an Act of Parliament and is either in the Office of the President, Prime Minister or Ministry of Health; (b) developed a time-bound national strategic plan with clear goals and priority interventions that are guiding the response at national and decentralized levels; and (c) a coordination framework that covers the key public sector ministries and civil society and addresses coordination from national to sub-national and community levels. A national response cannot be effectively managed without a monitoring and evaluation system. Each Partner State and EAC has put in place an M&E framework that supports tracking the performance in the implementation of their respective strategic plan.

In order to strengthen the response the following actions are recommended:

EAC

- The EAC Secretariat should coordinate development and harmonization of minimum standards for surveillance of HIV and AIDS issues and service delivery with the region
- The EAC should facilitate the harmonization of national HIV and AIDS strategic plan development and timeframe to enhance monitoring and evaluation, for better comparison across Partner States
- Strengthen the M&E system at the Secretariat in terms of structures and personnel to facilitate availability of high quality data for performance monitoring and reporting and linkage with the EAC Partner States

Partner States

- The mainstreaming of HIV should be revitalized and made a mandatory requirement for central government to approve sector and local government investment plans

Development Partners

- Development Partners should provide the necessary technical and financial resources for strengthening coordination between regional and in-country M&E systems for EAC and AU matters

CHAPTER 4: ELIMINATION OF NEW HIV INFECTIONS

One of the targets in the 2011 Political Declaration on HIV and AIDS by the UN Partner States is to reduce sexual transmission of HIV by 50% by 2015 using 2010 as the baseline. In order to achieve this, one of the key priorities is to understand the main routes of HIV transmission before appropriate strategies and interventions can be formulated. This chapter discusses the modes of HIV transmission and the most at risk populations among whom new infections are likely to occur in the region.

The countries in East Africa have invariably adopted the combination prevention approach in which the multiple interventions targeting behavioural, medical and cultural drivers of the epidemic are addressed to prevent occurrence of new infections. This chapter has documented population-based evidence on the levels of behavioral determinants of the HIV transmission including early sexual debut among youth, sero-discordance, attitude to condom use, multiple partnership and condom use. Biomedical determinants on which information is provided includes safe male circumcision (SMC), HIV testing and provision of ART for prevention.

Partner States reviews indicate that Burundi, Kenya and Rwanda are on track to meet the 2011 Political Declaration on HIV and AIDS target on reduction of sexual transmission of HIV. On the other hand, Uganda and Tanzania are unlikely to meet the target (Annex I).

4.1 Modes of Transmission and Most at Risk Populations in the Region

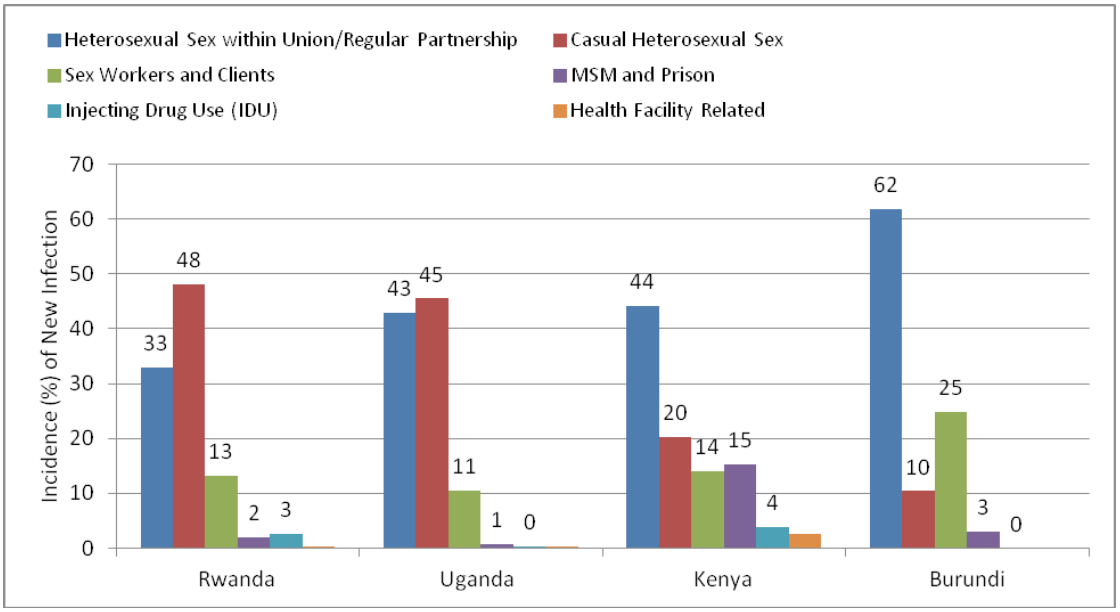
4.1.1 Mode of HIV Transmission in EAC Partner States

There is need to know the mode of HIV transmission in order to develop appropriate strategies and interventions for addressing the main routes of transmission. Throughout East Africa the dominant method of HIV transmission is through sexual intercourse as is documented in the Mode of Transmission studies conducted in Kenya (1), Rwanda (2) and Uganda (3) and also in the demographic and health surveys as well as the indicator surveys (4, 5, 6, 7, 8).

According to the mode of transmission studies carried out in Kenya, Rwanda, Uganda and Burundi (9), most new infections in East Africa are expected to occur in couples who engage in heterosexual intercourse within a union/ regular partnership5, and among (i) those who practice casual sex, (ii) among sex workers and their sex clients and (iii) among the prison population and men having sex with men (MSM). Thus, heterosexual sex within union/regular partnership or mutual monogamous heterosexual sex is estimated to be responsible for between a third and three fifths of the new infections in four of the Partner States as is shown in the figure below. Casual sex, including that involving multiple partnerships, is projected to account for nearly half of the new infections in Rwanda and Uganda, but also for one fifth and a tenth of new infections in Kenya and Burundi respectively. In each of the Partner States, transmission of HIV infection among sex workers and their clients is responsible for about one tenth of the new infections except in Burundi where it is responsible for a quarter of the new infections. Furthermore, in Kenya, MSM and Prison populations are expected to contribute about 15% of the new infections in that country; in the other countries, MSM contributes to three percent or less.

5 Heterosexual sex within union/regular partnership or Mutual monogamous heterosexual sex (MM) refers to sex during the last 12 months that occurred in marriage or with someone you are living with and with only one partner each in which case the only risk of HIV infection would be through discordance

Figure 4: Percentage Incidence of HIV by Mode of Transmission



Source: KNAC (2009), CNLS (2009) and UAC (2009), Burundi (2012)

As noted above, the MOT studies are old and need to be updated.

4.1.2 Key Populations in EAC Partner States

There are some populations in EAC Partner States whose risk of HIV infection is more than that in the general population. It was already mentioned that women in all the five countries had a higher prevalence rate than men and that young women are also at high risk. However in addition to this, there are other groups of people who are that are at increased risk. As presented below, there is considerable variation in the terminologies used in describing the key populations and there is also lack of comparable and new information on these key populations in many countries of the region.

In Burundi, the MARPs include professional sex workers, uniformed service men and women, displaced people, homosexuals, IDU, discordant couples, fisherfolk and long distance truck drivers (10).

In Kenya, for example, it was reported (11) that sex workers, men who have sex with men (MSM), people who inject drugs, prisoners, migrant workers (e.g. long distance truck drivers, fisherfolk and mobile professionals) have higher HIV-related risks and vulnerability compared to that of the general population in the country.

In Uganda, the current NSP (12) and National Prevention Strategy (13) categorize MARPs to include fishing communities, sex workers (SWs) and partners of sex workers, men who have sex with men (MSM), IDUs, uniformed services, Internally Displaced Persons (IDPs), mobile populations such migrant workers, and Persons living With Disability (PWD).

Table 6: HIV Prevalence among Most at Risk Populations in EAC Partner States

Partner States	Source		Most at Risk Population				
			Sex Workers	MSM	IDU	Fisherfolk	Prisoners
Burundi	BSS 2011[1]		19	2		3	3
Kenya	MoH 2012		29	18	19	26	8
Rwanda	CNLS 2009		51				
Uganda	Crane 2010a		33	14	-	22	13b
Tanzania	TACAIDS 2008			12	25	8	-
Zanzibar	Unguja	ZAC, MOH 2011	19.3	2.6	11.3		
	Pemba		18.8	5.0	8.8		

[a]The Crane study was a small study conducted only in Kampala hence not appropriate to extrapolate to the national level
[b] Prisons annual HIV/AIDS 2012 report

In Kenya 29.3% of all sex workers nationwide were estimated to be living with HIV in 2012 when the prevalence of HIV was 6.1% among Kenyan adults. In Uganda sex workers had 33% prevalence (14) compared to 7.2% among the general adult population. It was reported in Kenya (15) that one of the reasons why there are migrant sex workers is because of continuing migration trends into and from Kenya (or any other Partner State) due to East African Community (EAC) integration, climate change, urbanization, economic development and continuing humanitarian challenges in neighboring countries. Thus, the female sex workers (FSWs) in Nairobi are from Ethiopia (31.2%), Tanzania (27.6%) and Uganda (27.6%), followed by Somalia (11%), Democratic Republic of Congo (1.3%), Sudan (1%), and Rwanda (0.2%). Against this background, efforts to estimate the number of SWs are complicated because commercial sex is illegal in the region and many sexual activities involve some transactional component making it difficult to categorize them as commercial sex work.

It was also estimated that 18.2% of Kenyan men who have sex with other men (MSM) were living with HIV in 2010; in Uganda the prevalence of HIV among MSM was 13.7%. In Zanzibar (16), the prevalence of HIV infection was 12.3%. However, in addition to this there were also other infections, namely, Hepatitis C virus (HCV) infection (14.7%), Hepatitis B virus (HBV) infection (4.6%) and HIV and HCV co-infection at 5.3% while co-infection of HIV and HBV was at 0.9% among MSM. It should be noted that bisexual activity is also common in East Africa. For instance, in Zanzibar 70.8% of MSM were reported to be having non-paying and paying female sex partners while in Kenya 40% of all MSM have ever been married to women and 13% of all MSM are still currently married to a woman.

Injecting drug use is a very efficient route of HIV transmission. In this regard, in Kenya white heroin used to be the primary drug of injection but now polydrug use with cannabis, rohypnol and other drugs is more common (15). The prevalence of HIV was 18.3% with the rate among women being almost thrice (44.5%) compared to 16.0% for male IDUs. Sharing of syringes is common among IDUs due to lack of access to new needles or cost and pressure from other users or being in prison. In Zanzibar, where HIV prevalence ranges from 0.6% in the population to 0.9% in antenatal clinic attendees, it was found that MSM and inject drugs (MSM-IDU) are particularly vulnerable to HIV infection and have the potential to transmit HIV across multiple populations through their male and female sexual partners and injection drug-using partners. Among MSM-IDU, infection with HIV (24.7%), HCV (22.2%), HIV and HCV co-infection (29.6%) were higher than in MSM non-IDU where the infections for HIV, HCV and HIV/HCV co-infections were 10.6%, 14.0% and 9.8% respectively. HB infection was at 3.8% for MSM-IDU but higher for MSM non-IDU at 4.5% (16, 17).

Fishing communities also have a higher prevalence of HIV than the rest of the population in the EAC Partner States. While 4.6% of men and 6.6% of women ages 15-49 were infected with HIV and ANC prevalence among ANC attendees was at 8.2%, HIV prevalence among fishing communities in Tanzania is around 7.6% with women in fishing communities experiencing more (11%) than their male (6.3%) counterparts (18). In Kenya, the KDHS 2008-09 survey (5) had estimated the national HIV prevalence at 6.3% for age group 15-49 years with a higher proportion of women (8.0%) than men (4.3%) infected. However, the HIV prevalence in the fishing community (19) was at 26.2% with prevalence being highest among the fisherfolk who are widowed (61.1%); those in age 35-44 at 42.1% and those separated or divorced at 41.7%. In Uganda (20), the average prevalence of HIV among the fishing communities was found to be 22.5% (ranging from 15-40% in some fishing communities) which was three times as high when compared to that among the adults in the country.

In East Africa, evidence is limited regarding HIV prevalence in the prison population. However, Kenya's modes-of-transmission study estimated that 10% of male prisoners were living with HIV. On the other hand, in Uganda, it was found in 2008 that prevalence of HIV was at 11.2%, higher among female prisoners (13%) compared to their male counterparts (11%) (21, 22).

The EAC Secretariat worked in collaboration with the International Organization for Migration (IOM) in seeking ways to institute a coordinated scale-up of comprehensive health programming along transport corridors in East Africa and in particular at One Stop Border Posts (OSBP). This was to promote access to services for vulnerable populations including mobile populations along the corridors and minimize duplication of effort. The Secretariat also brought together representatives from regional policy bodies, government ministries, health providers, transport unions,

private companies and other stakeholders to share experiences and to discuss the way forward for HIV and broader health programming along transport corridor within EAC. Furthermore, the studies were also conducted in the region on cross-border health situation (23, 24). This was to provide a regional perspective on the HIV disease burden at cross border communities in the East Africa region and document the existing gaps in health and HIV and AIDS services available for these populations.

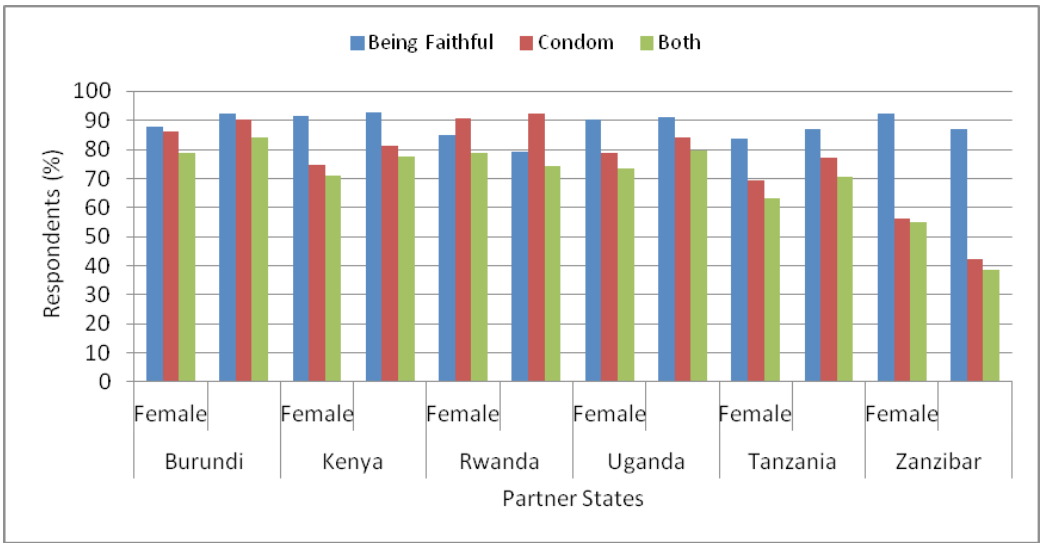
4.2 Knowledge and Awareness of HIV

4.2.1 Knowledge of Means of Preventing HIV Transmission

In East Africa, there is universal knowledge about AIDS. Over 99% women and men aged 15-49 have heard of AIDS in all countries of East Africa. Against this background, since the epidemic was noted in the region, it has been advocated and promoted throughout East Africa that abstaining from sex, being faithful to one uninfected partner, and consistently using condoms with a sexual partner of unknown sero-status are important ways to avoid acquiring HIV infection. The information presented here are from BDHS-2010 (4), KDHS 2008-09 (5), RDHS -2010 (6), UAIS -2011 (7) and THMIS -2011 (8).

In the region, among adults aged 15-49 years, knowledge about fidelity (i.e. limiting sexual intercourse to one uninfected partner or being faithful to one uninfected partner) as a method of preventing HIV infection was found to be quite common with about nine out of ten adults having the knowledge. On the other hand, knowledge that condoms can be used to prevent HIV infection was less common with only four out of five adults having it. Lastly, knowing that both using condoms and limiting sexual intercourse to one uninfected sexual partner was only found in seven out of ten adults in the region with more men knowing than females except in Rwanda where the reverse was true.

Figure 5: Level of Knowledge of Being Faithful and Using Condoms to Prevent HIV Infection among adults aged 15-49 years in EAC Partner States



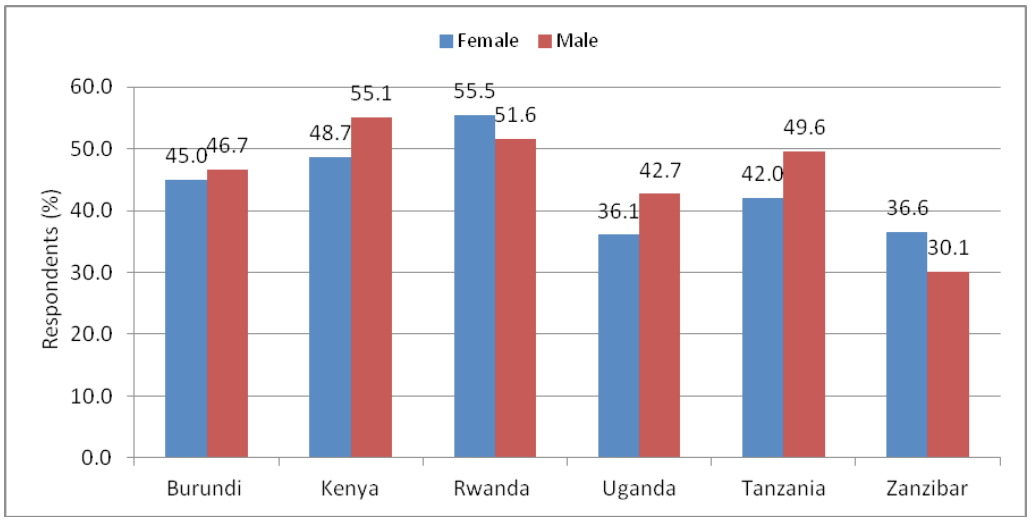
Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011) and THMIS (2011).

4.2.2 Comprehensive Knowledge about AIDS

Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about transmission---that the AIDS virus can be transmitted through mosquito bites and by supernatural means. In the East African region (4, 5, 6, 7, 8), less than half the adults in Burundi, Uganda and Tanzania have comprehensive knowledge about AIDS. In Kenya and

Rwanda where the knowledge is more widespread, less than two out of three adults have such knowledge. More men than women in each of the Partner States have comprehensive knowledge about AIDS, except in Rwanda where only 52% of men compared to 56% of women had such knowledge.

Figure 6: Level of Comprehensive Knowledge about AIDS among adults aged 15-49 years



Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011) and THMIS (2011).

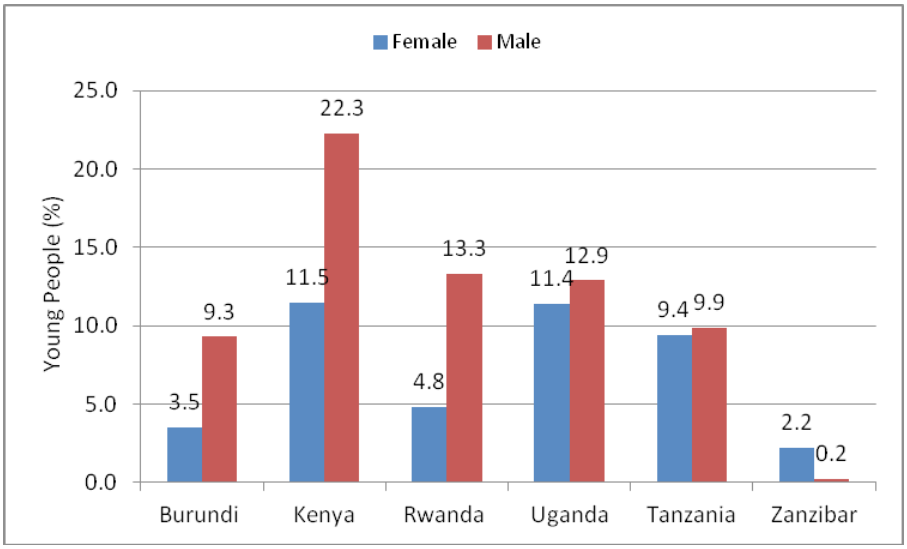
Regarding comprehensive knowledge about AIDS among inmates, about 30% of male prisoners and 35% female prisoners lacked comprehensive knowledge about HIV and AIDS and about 50% had incorrect beliefs about HIV and AIDS while about 20% believed HIV had a cure. It was also found that about 30% considered themselves at risk of acquiring HIV while in prison attributing the risk to sharing shaving instruments (62%) and unsafe sexual behavior (7%). The key drivers of new HIV infections among prisoners include unprotected MSM and heterosexual intercourse, sharing of unsterilized skin piercing instruments, drug abuse and violence (22). In this regard it should be noted that drug criminalization and drug-related crime means many prisons in the region are filled with people who use drugs with some already infected with HIV.

4.3 Behavioral Interventions

4.3.1. Early Sexual Debut among Youths

Although there is a strong advocacy and promotion of abstinence for young people, many young men and women in the EAC Partner States (4, 5, 6, 7, 8) have already had sex by the age of 15. More than one in five boys age 15-19 years in Kenya have had their first sexual debut before age 15 compared to their counterparts in Burundi where only one in ten had done so. Burundi is also the country where the least number of young girls (4%) had initiated sex by age 15 compared to the other countries where more girls had already experienced sexual intercourse by age 15. While in each country more boys than girls have had sex by age 15; in Uganda about 12% of both boys and girls age 15-19 had sex by age 15. According to the Zanzibar UNGASS Progress Report 2012, the percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 was at 2.2%.

Figure 7: Percentage of women and of men age 15-19 who had first sexual intercourse by 15 years

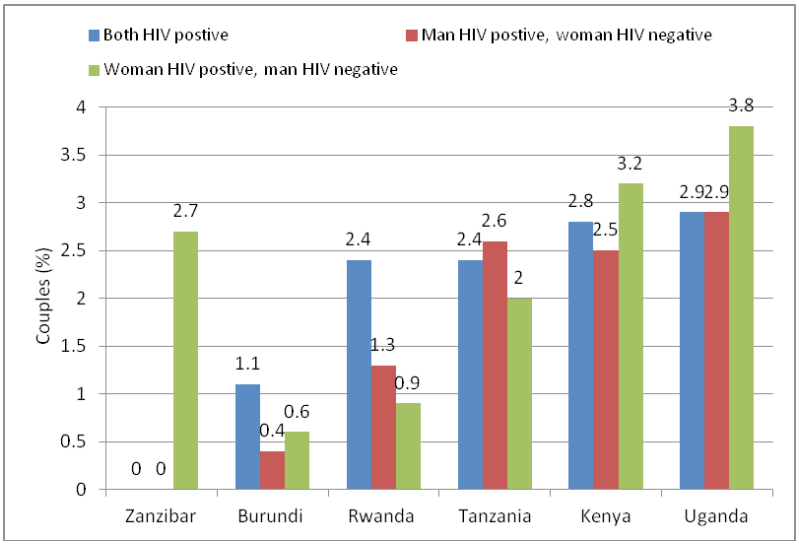


Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011) and THMIS (2011).

4.3.2. Sero-discordance in East Africa

In the EAC (4, 5, 6, 7, 8), over 90% of the couples are both negative implying that only in one out of ten couples in the region has at least one partner that is infected. In this regard, less than three percent of the couples have both partners HIV positive. However, in Uganda, Tanzania and Kenya, nearly three percent of couples have the man HIV positive and woman HIV negative. On the other hand, there are relatively more couples with woman HIV positive and man HIV negative in Uganda and Kenya than the opposite; this elevated risk of HIV infection among women is consistent with the situation in the general population where women have a higher prevalence of HIV than men. In Burundi and Rwanda, HIV sero-discordance is not very common, occurring only in 1% and 2% of the couples respectively.

Figure 8: Prevalence of Sero-discordance among Couples in EAC Partner States



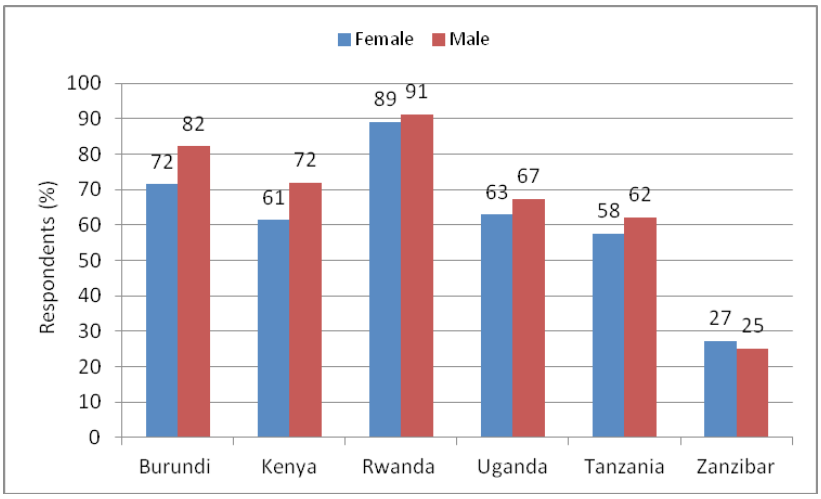
Source: BDHS (2010), KDHS(2010), RDHS (2010), UAIS (2011) and THMIS (2011).

4.3.3 Attitude to Condom Education

There is a positive attitude towards condom education in the EAC (4, 5, 6, 7, 8). More than two out of three East African women and men aged 15-49 years agree that children aged 12-14 years should be taught about using a condom to

avoid AIDS. In particular, (a) more men than women in all the countries are agreed on this issue and (b) about nine in ten women and men in Rwanda compared to only six out of ten in Uganda have no problems in having their children taught about condom use in protecting oneself against HIV infection. This is a conducive environment for sexual and sexuality education in the region to the children before most of them become sexually active. Indeed, in Kenya, there is provision of age appropriate HIV and sexuality education for primary, secondary and tertiary school learners in the country. However, in the region, there is generally a lack of harmonization of information, education and communication (IEC) / behavioral change communication (BCC) interventions and inadequate availability of materials to ensure effectiveness.

Figure 9: Attitude towards Condom Education for Children aged 12-14 years

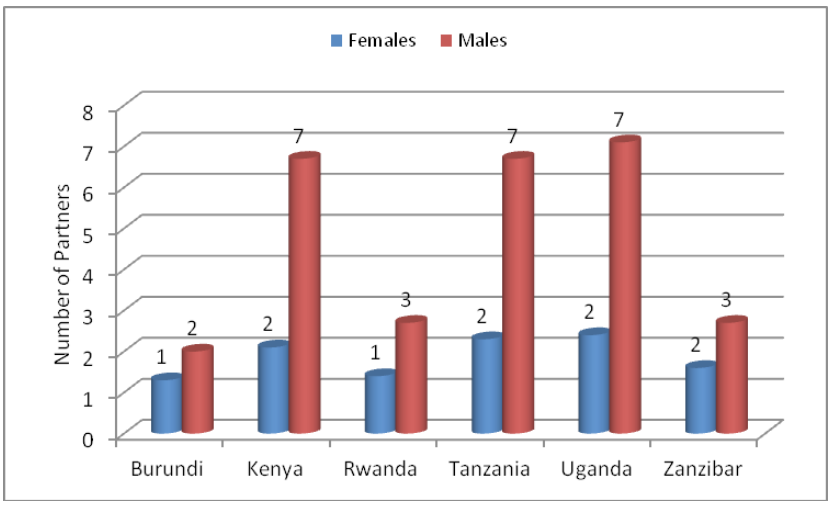


Source: BDHS (2010), KDHS(2010), RDHS (2010) and UAIS (2011)

4.3.4 Multiple Partnership and Condom Use

Multiple concurrent sexual partnerships are usually more risky than serial partnerships because they can create large, interconnected sexual networks whose members are at heightened risk of infection, especially if sexual intercourse in such relationships is unprotected. In the EAC (4, 5, 6, 7, 8), men are significantly more likely than women to have more lifetime sexual partners particularly in Kenya, Tanzania and Uganda compared to Burundi and Rwanda. In the former three countries, the mean number of sexual partners in a lifetime for men is seven while that for women is only two; in Burundi and Rwanda while women have only one life time partner, men have an average of two.

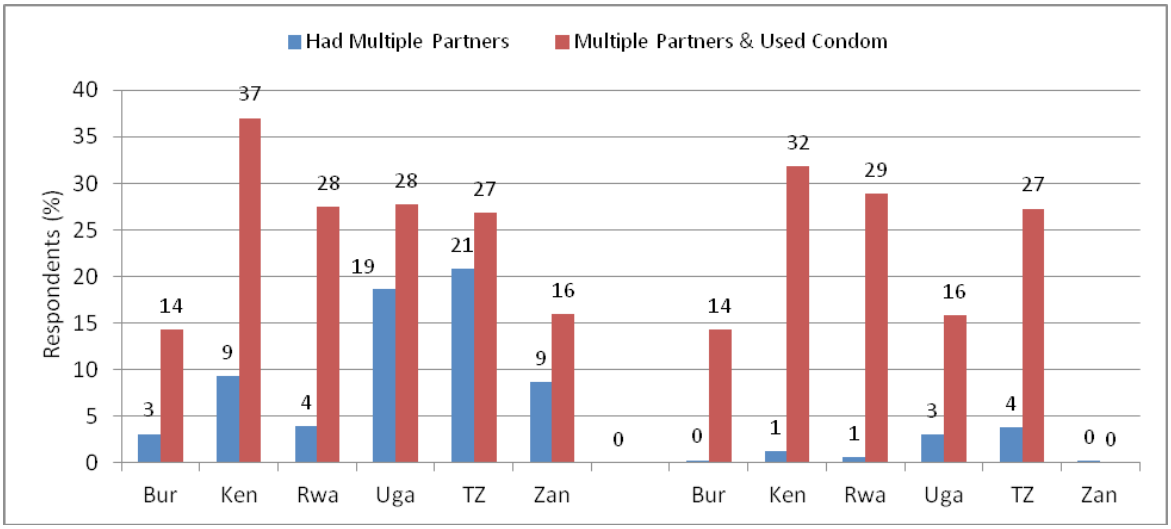
Figure 10: Number of Lifetime Sexual Partners among adults engaged in Multiple Sexual Relationships



Source: BDHS (2010), KDHS(2010), RDHS (2010), UAIS (2011) and THMIS (2011).

When the sexual practice of men and women in the last 12 months is considered, then multiple sexual partnership was found to be quite common among men in Uganda and Tanzania (compared to the other countries) because one in five men reported having had more than one sexual partner in the past 12 months.

Figure 11: Multiple Relationships and Condom Use among Men (left graph) and Women (Right graph)



Source: BDHS (2010), KDHS(2008-09), RDHS (2010), UAIS (2011) and THMIS (2011).

Sexual intercourse in multiple relationships in the EAC (4, 5, 6, 7, 8) tends to be unprotected because condom use in such sexual episodes is quite low. Thus, among the men and women that had multiple partners in the last 12 months, only about one in three of them in Kenya, Rwanda and Tanzania used a condom at the last intercourse. In Uganda, less than one in five men and women did so while in Burundi, where multiple sexual relationship is lowest, only one in ten used a condom. In Zanzibar where 8.7% of men and 0.2% of women have multiple partners, 16% of such men had used a condom. These findings imply that adults in the region are constantly vulnerable to HIV infection as they expose themselves through unprotected sex to many partners whose sero-status is unknown.

4.4 Biomedical Interventions

4.4.1 Safe Male Circumcision

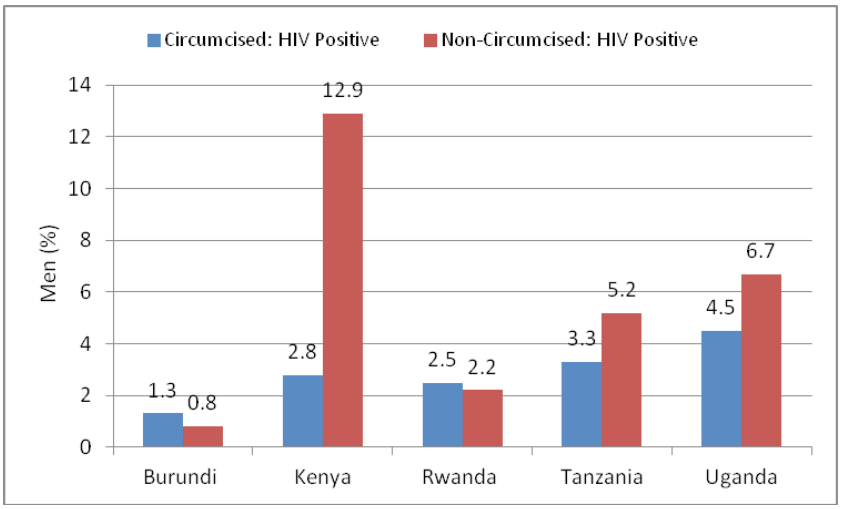
Male circumcision, the surgical removal of the foreskin of the male sexual organ has shown to help reduce the risk of acquiring HIV infection for a number of reasons. Firstly, the inner mucosa of the foreskin, which is removed through circumcision, is rich in HIV target cells. The removal of the foreskin furthermore causes more rapid drying of the penis after sex, bathing or urination, thereby reducing the likelihood of viral, bacterial or other sexual infections. When the foreskin is intact, the likelihood of abrasion and minute tearing during (especially violent) sex is high. Clinical trials in Sub-Saharan Africa including Kenya and Uganda have demonstrated that safe male circumcision (SMC) reduces HIV acquisition by about 50 - 60% among uninfected men. Accordingly, the practice has been scaled-up throughout the region (4, 5, 6, 7, 8). As a result of this, in Kenya, Tanzania and Burundi, over 85%, 72% and 33%6, respectively, have been circumcised while fewer men in Uganda (26%) and Rwanda (13%) have been circumcised. The low response observed in Uganda is mainly because of the delays that the country had in integrating safe male circumcision (SMC) among the key interventions to be promoted.

The contributions of circumcision are demonstrated here below where it is shown that in Kenya the prevalence of HIV among circumcised men was only 2.8% compared to 12.9% among those not circumcised. In Kenya too, the

6 This was the rate found in 2009 before scaling up SMC programme.

occurrence of sexually transmitted conditions was three times in non-circumcised men (6.1%) compared to those that were circumcised (1.5%) although in Tanzania it was also found that men who were not circumcised are nearly twice as likely to have STIs/genital discharge/sores/ulcers as those who have been circumcised (nine percent compared with five percent.

Figure 12: HIV Prevalence among Circumcised and Non-circumcised Men in EAC Partner States



Source: BDHS (2010), KDHS (2008-09), RDHS (2010), UAIS (2011) and THMIS (2011).

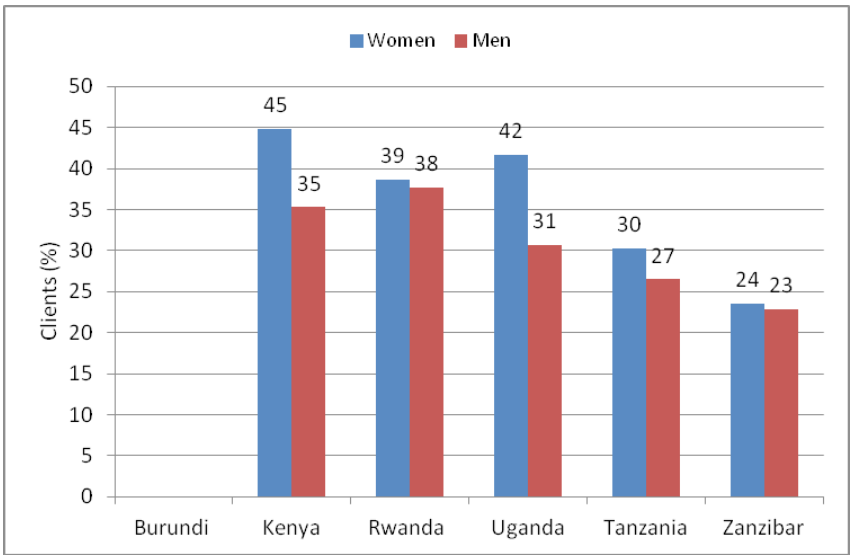
4.4.2 HIV Testing among Adults and Youth

HIV counseling and testing (HCT) is an entry point to many prevention, care, support and treatment services. When one establishes his/her sero status, he/she may access prevention services that (a) promote or facilitate behavioral change (b) provide elimination of mother to child transmission services (c) deal with STI prevention and treatment (d) educate and promote family planning. A positive test result gives opportunity for the person to access early medical care for opportunistic infections (OIs), antiretroviral treatment and preventive therapy for TB. Support programmes that PLHIV can access following a positive test result include those that (i) promote Positive Health, Dignity and Prevention (PHDP) that targets PLHIV and their needs so that they can live a healthy life while reducing the risk of transmission of the virus to other people (ii) enhance planning for the future (iii) normalize and de-stigmatize HIV and AIDS (iv) provide peer, social and community support. HCT also generates data that are necessary and critical for enhancing capacity building in planning, implementation and resource mobilization for the national response.

In all the EAC Partner States (4, 5, 6, 7, 8), more women tend to go for HIV testing than men. In Kenya, 57% of women compared to 40% men have ever tested and got their results; in Rwanda, the statistics were 76% and 69% respectively. On the other hand, in Uganda while 71% of women have ever tested and got their results, only 52% of the men had done so. In Tanzania, 62% of women and 47% of men have ever undergone a HIV tested and got their results.

In addition more women have taken the test recently compared to men. The percentage of such women ranges from 29% to 42% across the Partner States compared to a range of 23% to 38% for men.

Figure 13: Percent distribution of clients who got their results from the test taken in the last 12 months



Note: For Kenya, those aged 15 years to 64 years
Source: KAIS(2012), RDHS (2010), UAIS (2011) and THMIS (2011).

The youths in the region are less likely to go for a HIV test compared to the adults. Thus, while about 50-60% of the female youths have ever tested, only about a third of the boys have done so, all these statistics being lower than the corresponding one for the adults. The coverage of testing among youths in the last 12 months is much lower with less than two out of five youths having taken the test. The results from the recent tests among the youth are lower when compared to results among adults and also when compared to those among youth ever tested as is shown in the table below.

Table 7: HIV Testing among young men and women ages 15-24 years in East Africa

	Data Source	Ever Tested and Got Results		Tested and Got Results in Last 12 Months	
		Women	Men	Women	Men
Burundi	BDHS-2010	37.4	30.0	19	11
Kenya	KDHS	48	31	28	19
Rwanda	RDHS	59	49	37	32
Uganda	UDHS-2011	62	35	40	24
Tanzania	THMIS-2011	49	32	29	21

Lastly, with regard to biomedical interventions, in the EAC region, there is inadequate supplies of essential commodities for various HIV prevention interventions e.g. HCT and SMC kits and condoms.

4.5 Summary on Elimination of New HIV Infections

Data on mode of transmission of HIV in EAC Partner States is more than five years; many socio-economic, political and technological changes that may affect the rates of transmission have taken place thus requiring new sets of studies to be carried out.

In East Africa, most new infections are expected to occur (a) in couples who engage in heterosexual sex within a union/regular partnership, (b) among those who practice casual sex, (c) among sex workers and their sex clients and (d) among the prison population and men having sex with men (MSM) and IDUs.

Multiple sexual relationship is more common among men than women in the region. Unfortunately, less than a third of both men and women involved in such practices do not use a condom. Among the young people, sexual debut starts before the girls and boys are 15 years of age and it occurs more among the boys than girls.

Safe Male Circumcision (SMC) has been scaled up in the region but has only reached more than three quarters of the men in Kenya and Tanzania, yet the prevalence of HIV among un-circumcised men in Kenya was found to be more than four times that in circumcised men. In all the countries, less than 50% of adults know their HIV status through testing, the situation is worse among the youth who less than 40% have tested and got results in the last 12 months.

The challenges in the prevention in new infections include (a) limited information on key populations in some countries of the EAC (b) low condom use among multiple sexual partners and youth (c) low coverage of combination prevention interventions in the region.

In order to reduce the number of new infections significantly, the following actions are recommended:

EAC

- Enhance provision of combination prevention services among priority populations (including transport corridor workers) through establishing a minimum package of services along the EAC transport corridors for key populations
- Conduct social behavioral and survey studies on sub populations and dynamics in order to guide prioritization of programming and policy interventions

Partner States

- Update the mode of transmission studies
- Enhance the scale up of high impact combination prevention interventions such as safe male circumcision, ART, PMTCT, condom promotion, treatment as prevention, targeting sub populations contributing highly to new infections in the region
- Target and engage young people(young positives, OVC, girls etc) in the implementation of HIV services in and out of school

CHAPTER 5: ELIMINATING NEW INFECTIONS AMONG CHILDREN AND KEEPING THEIR MOTHERS ALIVE

Elimination of new infections among children by 2015 and substantially reducing AIDS-related maternal deaths are targets that the UN General Assembly expects all countries to embark on. Indeed, the Global Plan towards the elimination of new infections among children has identified Kenya, Uganda and United Republic of Tanzania among the 14 countries in eastern and southern Africa characterized as priority countries because they together with eight other countries around the world account for nearly 90% of pregnant women living with HIV. This chapter therefore presents the different approaches being used in the region for eliminating mother to child transmission of HIV. The chapter also discusses the impact of elimination of mother to child transmission interventions (a) in reducing infection among newly born children and (b) in reducing the risk of mortality among HIV positive pregnant or post-partum women in East Africa Community Partner States.

Reviews indicate that all five Partners States are on track to meet the 2011 Political Declaration on eliminating new HIV infections among children and reducing AIDS-related maternal deaths by half (Annex I).

5.1 Global Effort in Elimination of Mother to Child Transmission

In 2011, a Global Plan towards the elimination of new infections among children by 2015 and keeping their mothers alive was launched at the United Nations General Assembly with two high-level targets, namely, to reduce the number of children newly infected with HIV by 90% and to reduce the number of pregnancy related deaths among women living with HIV by 50%. The Global Plan identified 22 priority countries (14 of which are in eastern and southern Africa), which together account for nearly 90% of pregnant women living with HIV; among these are 14 countries in eastern and southern Africa including Kenya, Uganda and United Republic of Tanzania.

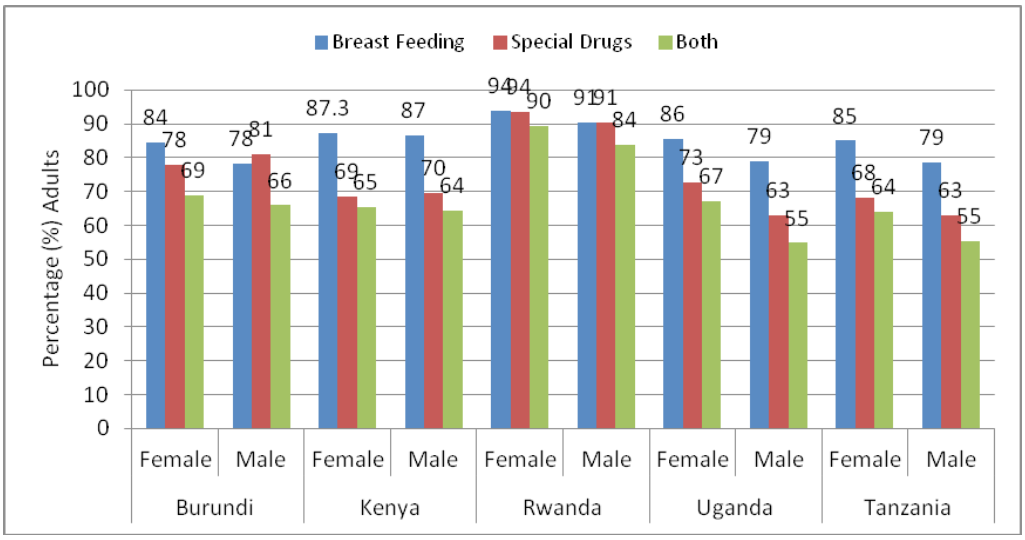
Rwanda is the only East African country that does not fall in the category of the 22 priority countries with the heaviest burden of PMTCT in the world. Rwanda also does not fall among the 22 PMTCT high burden countries that include Burundi, Kenya, Uganda and Tanzania (1).

5.2 Regional Efforts towards Elimination of Mother to Child Transmission of HIV Infection

5.1.1 Knowledge about Mother-to-Child Transmission of HIV

More than four out of five adults aged 15-49 know that HIV can be transmitted from a mother to her child by breastfeeding (2, 3, 4, 5, 6). Knowledge about special drugs that a doctor or nurse can give to a pregnant woman infected with the AIDS virus to reduce the risk of transmitting the virus to the baby is somewhat less widespread compared to that of breastfeeding except in Rwanda and Burundi as is shown in the figure below. The combined indicator shows that more women than men in the region know both methods of preventing mother to child transmission of HIV; in Rwanda, the combined knowledge is at about 85% while it is only between 60% in Tanzania and 70% in Burundi.

Figure 14: Knowledge of Breastfeeding and Use of Special Drugs in Prevention of Mother to Child Transmission of HIV among Adults in EAC Partner States



Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011), THMIS (2011)

5.1.2 Approaches for Eliminating Mother-to-Child Transmission of HIV

The World Health Organization (WHO) recommends the implementation of a comprehensive strategic approach for preventing HIV infection among infants and children that includes four prongs. These are (i) primary prevention of HIV infection among women of childbearing age (ii) preventing unintended pregnancies among women living with HIV (iii) preventing HIV transmission from women living with HIV to their infants and (iv) providing appropriate treatment, care and support to mothers living with HIV and their children and families.

Prong 1: New HIV infections among women 15-49: The number of new HIV infections among women aged 15–49 in the EAC Partner States declined by 4-10% between 2009 and 2012 (7). In Burundi and Tanzania, the reduction in HIV infections among women was 10% while in Uganda and Kenya it was four and eight percent respectively. This is rather a modest reduction if the target of eliminating mother to child transmission by 50% is to be achieved by 2015.

Table 8 : Estimated New HIV infections among women 15-49 years

Global Plan Country	2009	2012	Percentage Reduction
Burundi	2,000	1800	10
Kenya	50,000	46,000	8
Uganda	70,000	67,000	4
United Republic of Tanzania	42,000	38,000	10

Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

Prong 2: Prevention of unwanted pregnancies: Women living with HIV need regular access to and uptake of family planning services in order to help them plan their pregnancies better and to avoid unintended pregnancies. About 70% of the married women in East Africa have their family planning needs met. The unmet needs for these services however vary from country to county (7), being highest in Uganda (34%) and lowest in Tanzania (25%) but medium in Burundi (32%) and Kenya (26%). The RDHS (2010) indicates that the unmet need for family planning among married women was 19% in Rwanda. These results cover the period 2009 and 2011 because there is generally a limited documentation of access to and uptake of family planning services by women.

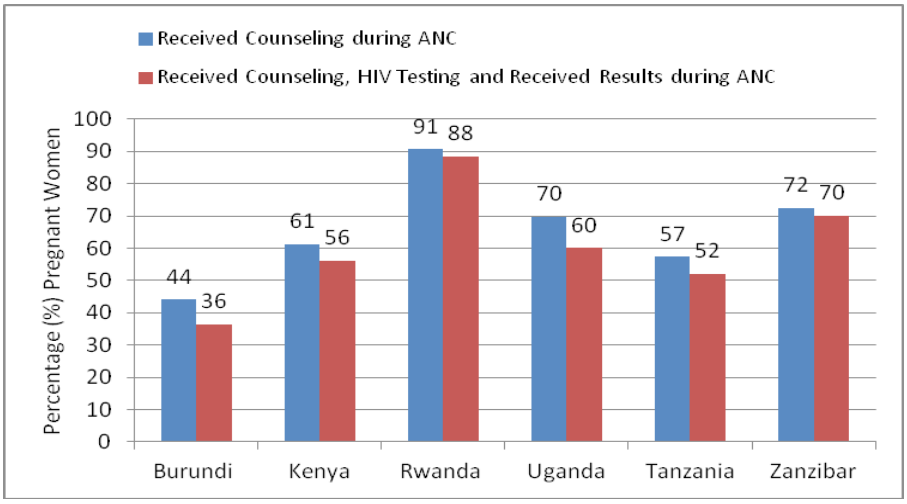
Table 9: Estimated Unmet Need for Family Planning for Women

Global Plan Country	PREVIOUS		CURRENT	
	Year	Unmet	Year	Unmet
Burundi	2009	33	2010	32
Kenya	2009	26	2009	26
Uganda	2009	31	2011	34
United Republic of Tanzania	2009	29	2010	25

Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

Prong 3: Mother to child transmission: All women should be counseled about HIV during antenatal care (ANC) and offered a test. Treatment exists that can significantly reduce the chance of an infant becoming infected with HIV from an infected mother during childbirth. Even where treatment is not available, new mothers infected with HIV should receive counseling on infant feeding practices best for their baby and on future pregnancy choices. However, 88% of pregnant women in Rwanda received counseling, HIV testing and got results during ANC compared to only 60% in Uganda and 56% and 52% in Kenya and Tanzania respectively. These proportions were identical in magnitude and pattern across the Partner States for the pregnant youths aged 15-24 years who attended the ANC (2, 3, 4, 5, 6). This is partly because, in the region, many women make less than four visits to ANC during their pregnancy.

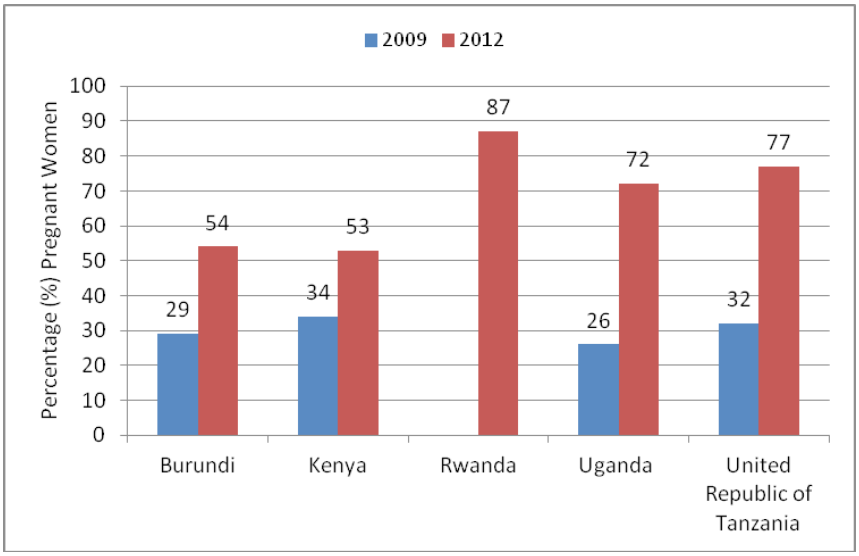
Figure 15: HIV Testing (%) among Pregnant Women Attending ANC



Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011), THMIS (2011)

Percentage of women receiving ARVs (excluding single dose nevirapine, sdnvp) to prevent MTCT: There has been considerable improvement in the proportion of pregnant women that received ARVs to prevent MTCT across the region (7). In Uganda and Tanzania there was nearly an increase of 50% points from 26% to 72% while it was less than 30 percentage points for Burundi (from 29% to 54%) and Kenya (from 34% to 53%). During 2012 Rwanda provided ARVs for PMTCT to over 87% of HIV positive pregnant mothers.

Figure 16: Percentage of women receiving ARVs (excluding sdnvp) to prevent MTCT



Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

Prong 4: Treatment, care and support to mothers and their children

Many HIV+ women are receiving ART for their own benefit: There is a good level of access to ART by women living with HIV for their own health benefit although variation in this proportion of women who receive ART for their own good is apparent. In 2012, while only about 50% of women in Burundi (47%) and Uganda (47%) received ART for this purpose, nearly six out of ten women in Kenya (58%) and Tanzania (56%) also got such drugs (7).

Table 10: Estimated Percentage of HIV positive women receiving ART for their own health

Global Plan Country	2009	2012
Burundi	0	47
Kenya	42	58
Uganda	0	47
United Republic of Tanzania	17	56

Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

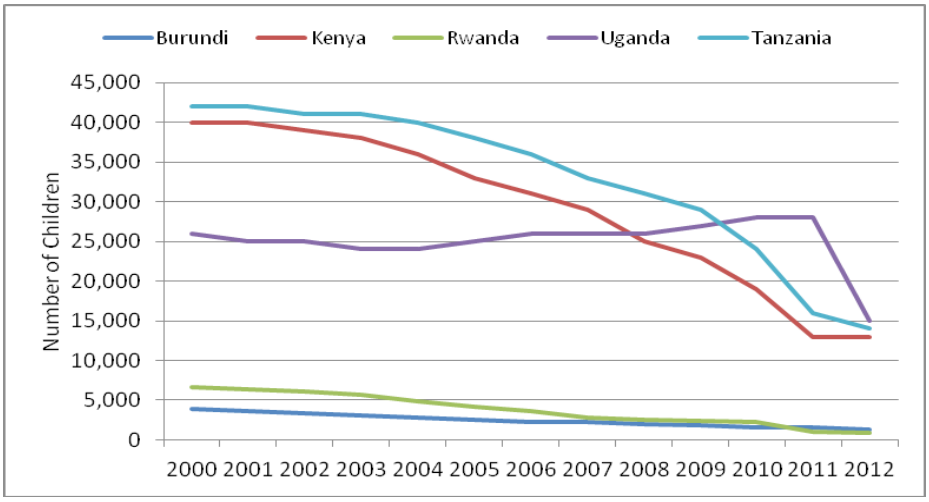
5.3 Impact of eMTCT

5.3.1 Reduction in Number of Children Newly Infected with HIV

There has also been some moderate reduction in the rate of mother to child transmission in the EAC region (8). In particular, the rate declined by one half in Uganda and Tanzania where in 2009 it was around 30% and in 2012 it was 15%. In the other countries, the rates fell from 33% to 25% for Burundi and from 26% to 15% in Kenya.

Although there was a total of 1.2 million children aged less than 14 who were newly infected with HIV between 2000 and 2012 in East Africa Partner States (Tanzania 35%, Kenya 31%, Uganda 27%, Rwanda 4% and Burundi 3%), there has been considerable progress within the region towards the elimination of MTCT. The total number of new infections in 2011 was only 44,150 representing a steady decline to 37% of what it was in 2000 which was at 118,500. This steady decline in the number of children newly infected with HIV in all the Partner States is shown in Figure 17 below.

Figure 17: Estimated Number of Children Newly Infected with HIV between 2000 and 2012



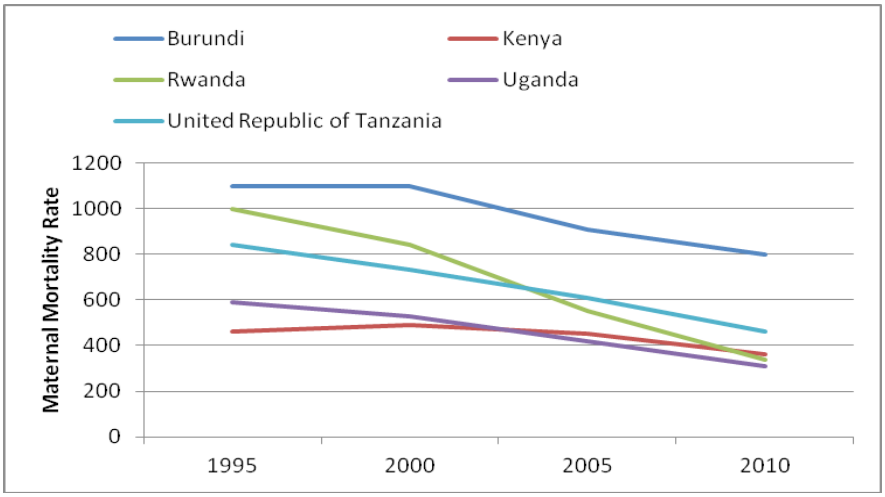
Source: UNAIDS (2013). Report on the Global AIDS Epidemic - 2013

There could be considerable impact of MTCT interventions in the EAC but many factors affect the regional efforts. These include (a) limited human resource to facilitate integration of SRH/family planning in eMTCT programme (b) inadequate health and M&E systems associated with under staffing, poor supply chain management resulting in stockouts of drugs and other essential commodities (c) inadequate community systems to support the eMTCT interventions including facilitation of referral and follow-up of eMTCT clients at community level.

5.3.2 Maternal Mortality among HIV Infected Mothers

It is known that the risk of mortality is about eight times higher among HIV-positive pregnant or post-partum women compared to their uninfected counterparts. In the 1990s maternal mortality was substantially high within the region because it was significantly contributed to by HIV morbidity and mortality. However, from the mid 2000s when ART became increasingly more widely available, maternal mortality rate has been rapidly declining in all the countries of the EAC particularly in the years 2005 to 2010 compared to the rates between 1995 and 2000 when HIV and AIDS epidemic was either at its peak or still escalating in the Partner States (9). For instance, in Burundi the rate declined from 910 to 800 between 2005 and 2010 compared to stagnation at 1100 between 1995 and 2000 while for Tanzania mortality reduced from 610 to 460 between 2005 and 2010 compared to 840 to 730 between 1995 and 2000 (9).

Figure 18: Maternal Mortality Rate in Partner States, 1995-2010



Source: WHO (2012). Trends in Maternal Mortality: 1990 to 2010

5.4 Summary on Elimination of Mother to Child Transmission

More than four out of five adults aged 15-49 know that HIV can be transmitted from a mother to her child by breastfeeding. Knowledge about antiretroviral drugs for preventing mother to child transmission of HIV is somewhat less widespread in the region.

The number of new HIV infections among women aged 15–49 in the East African region declined by 4-10% between 2009 and 2012. About 37% of the married women in East Africa have their family planning needs un-met.

The proportion of pregnant women attending antenatal clinic varies considerably across countries with 90% in Rwanda and 44% in Burundi. This observed scenario affect implementation of eMTCT in reducing the new infection in countries whose coverage is low.
There has been considerable improvement in the proportion of pregnant women that received ARVs to prevent MTCT across the region, having moved from less than 35% in 2009 to more than 50% in 2012. Many HIV positive women are also receiving ART for their own benefit.

There has also been moderate reduction in the rate of mother to child transmission in the East African Community. The number of new infections in 2011 was only 59,000 representing a steady decline to 50% of what it was in 2000 which was at 117,200.

Risk of mortality is about eight times higher among HIV-positive pregnant or post-partum women compared to their uninfected counterparts. However, from the mid 2000s when ART became increasingly more widely available, maternal mortality rate has been rapidly declining in all the countries of East Africa.

Some of the challenges experienced in prevention of mother to child transmission include limited human resource to facilitate integration of SRH/family planning in eMTCT programme and inadequate health, M&E and community systems.

In order to sustain the progress made, the following be done:

EAC

- Develop a regional strategy for strengthening community system to facilitate implementation of HIV and other health programs

Partner States

- Strengthen the integration eMTCT into maternal, new born and child health services
- Increase resource allocation for strengthening health systems (e.g. improve staffing, lab, supply chain management, M&E systems) for enhancing delivery of eMTCT, EID and other integrated services in the region
- Strengthen mechanism of ensuring universal access to services for pregnant women (ANC, eMTCT) and enhance scale up of option B+ as a strategy for expanding efficacious treatment throughout the EAC Partner States

CHAPTER 6: PROVISION OF ANTIRETROVIRAL TREATMENT

There has been considerable advocacy for provision of universal access to treatment, care and support services to people living with HIV and AIDS. Thus, reaching 15 million people living with HIV with lifesaving antiretroviral treatment (ART) by 2015 has been a global target since 2011. In this report, the infrastructure necessary for the delivery of ART services in the region is first presented before the level of access to ART among adults and women is discussed. In this regard, it is very important for children born to HIV positive mothers to be tested for HIV and, as soon as possible, put on treatment if found to be infected with HIV. Hence, this chapter also discusses access to ART among infants.

Reviews by the Partner States indicate that Burundi, Kenya, Rwanda and Uganda are on track to meet the 2011 Political Declaration on provision of ART to PLHIV. There was no indication on the likelihood of achieving the target for this indicator in the report from Tanzania (Annex I).

6.1 Provision of Antiretroviral Treatment to Adults

6.1.1 Facilities for Provision of ART among Adults

In the EAC, the number of facilities providing ART services has continued to increase. In Kenya, at least 1,829 facilities out of 7,422 health facilities were providing ART by 2012 (1) while in Tanzania, 1,176 facilities provided care and treatment to PLHIV by December 2010. In Uganda where ART services are provided in hospitals, health centers-IV (health facility at county level) and health centres-III (health facility at sub-county level), the number of health facilities providing ART increased from 475 to 573 between June 2011 and June 2012 (2). Similarly, in Rwanda, the health facilities that were offering care and treatment services to PLHIV increased from 336 to 430 between June 2011 and June 2012 (3). It is however, pertinent to note that in 2012, out of the 1,441 facilities in Uganda and 7,422 in Kenya, about 34% and 25% respectively were accredited to provide ART services. While all hospitals provided ART, a relatively smaller number of the lower level health facilities which are more in number and closer to the rural communities had not been accredited, thus accounting for the resulting low coverage in ART services by health facilities in the countries.

As discussed below, throughout East Africa, the increase in the number of health facilities providing ART has contributed greatly to the growth and expansion in access to ARVs and, indeed, the increase in uptake of ARVs by the PLHIV. These positives outcomes are however affected by inefficient supply chain in the region leading to shortage of ART drugs and other supplies and poor or non-functionality of some ART sites. They are also affected by inadequate referral linkages and systems affecting equitable access to ART by those eligible for treatment and ensure continuum of care as discussed further in this report.

6.1.2 Access to ART among Adults

Need and Access to ART among adults: ART is a lifelong therapeutic undertaking that is being scaled-up in the EAC because there is significant scientific evidence to show when PLHIV take ART as guided by WHO and adapted by Partner State Ministries of Health, the rates of opportunistic diseases and deaths decline markedly (4). In addition, there is evidence that provision of and adherence to treatment by the infected individual will also prevent transmission to a negative partner. This underscores the use of treatment for prevention. The table below shows that by 2012, there were nearly 2 million adults eligible for ART but only about 1.5 million got the treatment.

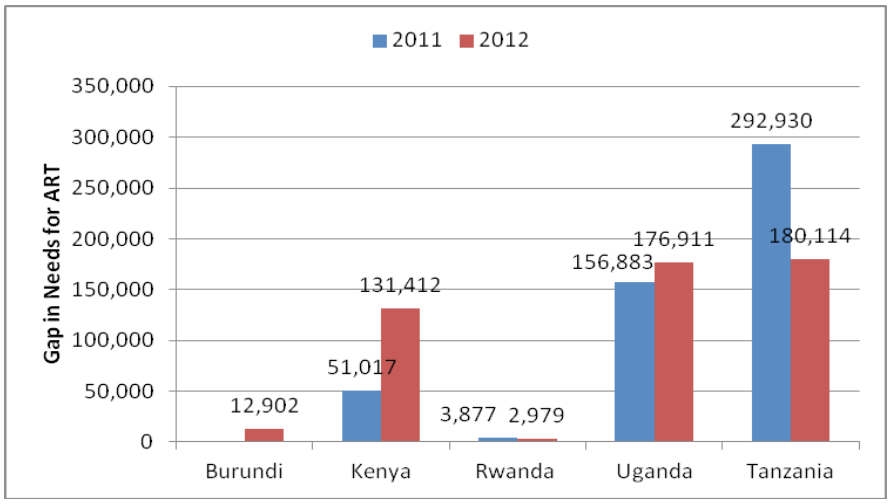
Table 11: Number of Adults Eligible for ART and on ART, 2011 and 2012

States	2011		2012	
	Adults Eligible	Adults on ART	Adults Eligible	Adults on ART
Burundi			40,000	27,098
Kenya	590,000	538,983	680,000	548,588
Rwanda	100,000	96,123	110,000	107,021
Uganda	470,000	313,117	580,000	403,089
Tanzania	570,000	277,070	580,000	399,886
TOTAL	1,730,000	1,225,293	1,990,000	1,485,682

Source: UNAIDS (2013).

A gap analysis was undertaken on the number of adults in need of ART and those actually on ART, basing on UNAIDS reports. The results show that between 2011 and 2012, there was an increase in the gap between the number of PLHIV that were, according to WHO 2010 guidelines (5), eligible for ART and those that actually accessed the drugs. Although the gap more than doubled for Kenya and increased moderately for Uganda between the two years, it decreased quite substantially for Tanzania and dismally for Rwanda (6). There was no data for comparison in the case of Burundi where the gap in 2012 was about 12,900 people.

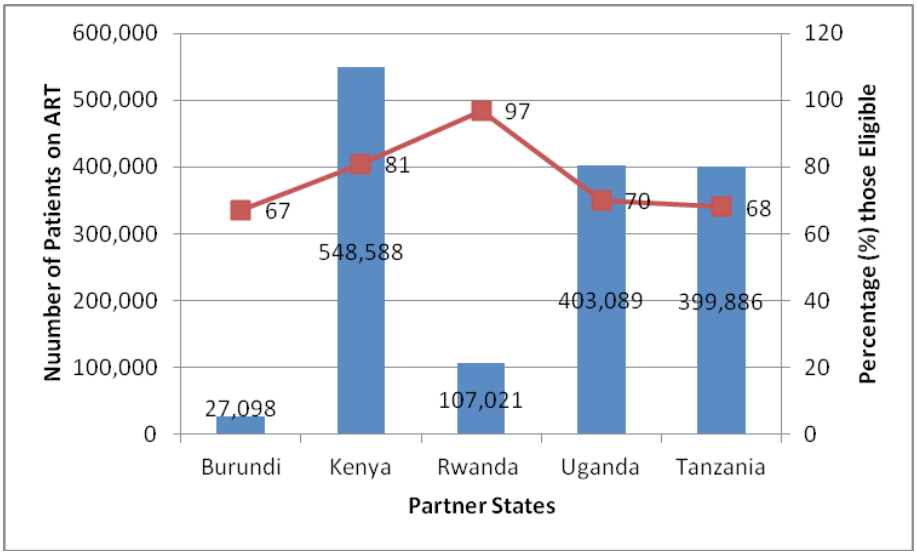
Figure 19: Gap between number of PLHIV in need and accessing ART in 2011 and 2012



Source: UNAIDS (2013). Global Report 2013

A more detailed look into the data for 2012 showed that in the region an estimated 1,990,000 PLHIV were eligible to ART according to the WHO 2010 guidelines (6). However, it was also estimated that only 1,485,682 were actually on treatment, meaning about 500,000 eligible persons were not covered under ART. This represents coverage of 75% implying that there was nearly half a million of un-met need for ART in the EAC region or nearly three out of ten PLHIV in need of ART were not getting such treatment. Yet according to the new guidelines highlighted below, the number of eligible PLHIV will increase substantially.

Figure 20: Access to Antiretroviral among PLHIV in East Africa



Note: Coverage is based on National Spectrum File
Source: UNAIDS (2013). Global Report 2013.

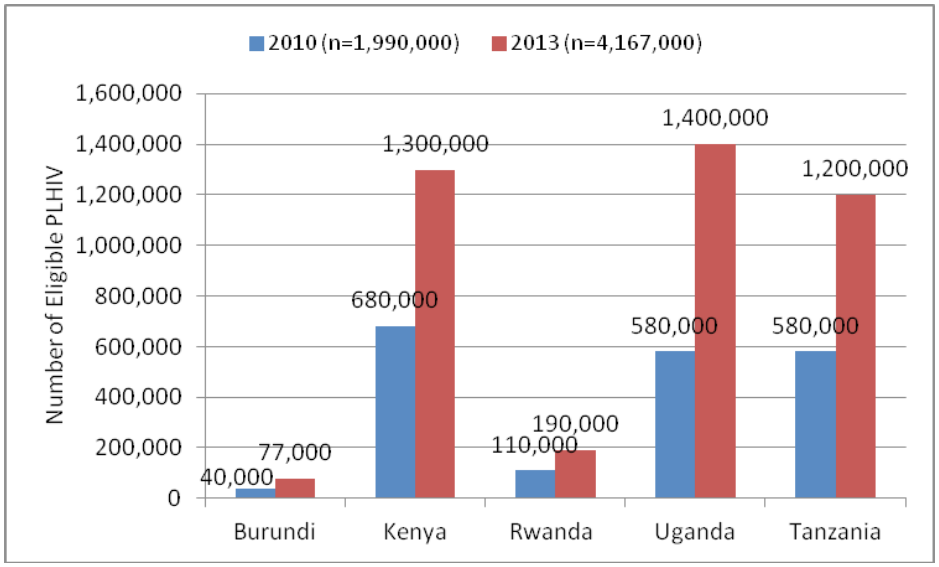
In order to get to zero–related deaths due to AIDS, the UN has revised the ART guidelines. The 2013 WHO guidelines (7) on the use of antiretroviral drugs for treating and preventing HIV infection now recommend a CD4 threshold of 500 for initiation of HIV treatment as is shown in the table below.

Table 12: 2013 WHO Guidelines for the Initiation of ART among Adults, Adolescents and Children

ADULTS	CHILDREN
ART should be initiated among all individuals • with HIV and CD4 count ≤ 500 cells/μL regardless of WHO clinical stage, • with HIV and active TB disease, • co-infected with HIV and HBC with evidence of chronic liver disease, and • among partners with HIV in sero-discordant couples to reduce transmission to the uninfected partner.	ART should be initiated in • all children infected with HIV below the age of five years, regardless of WHO clinical stage or CD4 count, • all children infected with HIV with severe or advanced symptomatic disease • all children infected with HIV older than five years of age with a CD4 count ≤ 500 cells/μL, regardless of WHO clinical stage.

As a result of this, it is projected that in East Africa, the number of PLHIV that are eligible to ART will double in Burundi, Kenya and Rwanda but more than double in Uganda and Tanzania (6). EAC is already working with Partner States to develop guidelines on adoption of the new 2013 WHO guidelines. In general, the total of such people will increase from about 2 million to over 4 million. This significant change in the number of people that become eligible for ART has a huge financial implication in the national response. As discussed in the section under funding, most of the resources for ART in the region have to-date come from development partners. The Partner States will therefore have to seriously embark on looking for other opportunities within and outside traditional sources of financing in order to meet this important investment need that has a direct impact on the wellbeing and productivity of the people of the region. Fortunately, the EAC HIV Unit is already working with Partner States on harmonizing the adoption of the new guidelines on sustainable financing.

Figure 21: Number of PLHIV Eligible to ART according to Guidelines of 2010 and 2013



Source: UNAIDS (2013). Global Repot 2013.

6.1.3 Retention in Care of ART clients

There is lack of consistent data across the Partner States on retention in care of ART clients. However, available information indicates that in Uganda, the percentage of clients on ART after 12 months of initiation of treatment, has increased from 83.6% to 84.1% between 2010 and 2011; death and loss to follow-up accounted about 16% in both years. While in Kenya, the percentage of patients who remain enrolled in treatment programmes one year after starting antiretroviral therapy actually declined over time, from 88.1% in 2004 to 80.5% in 2007 and 76.7% in 2008, in Burundi, the rate of retention was 90% in 2011.

In Tanzania, retention rate and follow-up is also weak according to NACP. About 65% of children of up to 12 months and 54% of 24 months are retained for treatment and the remaining are lost for follow-ups or die. In a study (8) conducted in Rwanda it was observed that non-adherence to ART was attributed to: (a) forgetfulness which made PLHIV to miss taking their drugs; and (b) being away from home. The study reported that these findings were similar to other studies carried out in several other African studies as well as in studies conducted in resource-rich settings.

It was also found that although HIV-positive people should not receive most live vaccines such as chickenpox, smallpox, yellow fever, polio and typhoid vaccines (13), some countries in EAC still require travelers living with HIV to get vaccinated with such live vaccines.

6.2 Access to Antiretroviral Treatment Among Infants

6.2.1 Facilities for Provision of ART to Infants

One of the key aspects in elimination of MTCT is that of enhancing availability, access and uptake of ANC services to the women. The number of ANC facilities offering PMTCT services needs to be increased to allow greater access by women. Coverage of PMTCT service provision at the ANC sites in East Africa varies considerably. By 2010, the coverage was quite good in Kenya (92%), Tanzania (90%) and Uganda (80%) but low in Burundi (35%) (9). In order to support these facilities and PMTCT service provision, however, in all these four countries, (a) action plans for PMTCT had been decentralized to lower level health and ANC facilities (b) PMTCT plans have been costed (c) national guidelines on PMTCT and infant feeding in line with WHO 2010 recommended guidelines on ARVs for PMTCT were in place and disseminated (d) policy review to decentralize and task shift essential HIV activities to the primary care and community levels were carried out.

Early Infant Diagnosis (EID) Services: In the absence of treatment, fifty percent of HIV-infected infants born to HIV-infected mothers may die before their second year of life. Thus, timely diagnosis and prompt access to treatment by these infected children is of utmost importance and necessity.

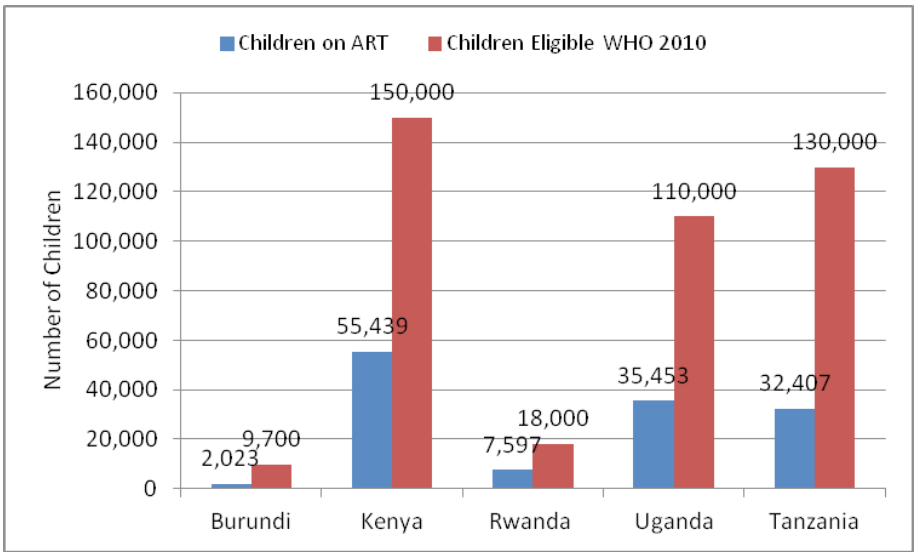
In Uganda, a consolidated laboratory for EID was established at the Central Public Health Laboratories (CPHL) with appropriate transport hubs at district level. By 2011 it was supporting services to 800 health facilities. In Kenya, by 2009 at least 1,322 facilities nationwide offered EID, having increased from just over 866 in 2008 (1). In Rwanda, specimens are collected from health facilities and transported to National Reference Laboratory (NRL), where HIV DNA PCR is performed. Thus, by 2012, out of the 597 health facilities in Rwanda, 416 were collecting DBS/PCR samples (70%) and EID results notification operated in all 416 health facilities performing DBS (100%) (10). In Tanzania, 70% of health facilities do not provide EID services and only 21% of HIV exposed infants access EID (11).

6.2.2 Access to ART among Children

ART coverage among children <15 years: It is very important for all children born to HIV-positive mothers to be tested for HIV and, as soon as possible, put on treatment if found to be infected with HIV. This is because disease progression and death are usually rapid especially among infants infected during their mothers' pregnancy or during birth. Indeed, without an early treatment, about half of such children will die within the first year of life while for those infected during breastfeeding, about a half of them will also die within 2.5 years after infection if not treated.

There was an estimated total of 417,700 children in need of ART in the East African Community in 2012. Kenya and Tanzania each contributed to over a third of these children who were eligible for ART medication (6). This status was a result of some improvement in pediatric ART coverage between 2009 and 2012. The coverage has more than doubled between 2009 and 2012 for Kenya (from 18% to 38%), Uganda (17% to 33%) and Tanzania (10% to 26%) but increased modestly from 17% to 21% for Burundi. However, only 32% (132,919) of the estimated eligible children were on ART. This indicates that access to pediatric ART in the EAC region is unacceptably lower compared to that for adults whose coverage is at 75%. This means that out of the nearly 420,000 that were eligible for ART, about 280,000 of the children living with HIV were not receiving treatment and hence were likely to die within 2.5 years.

Figure 22: Access and Eligibility to ART by Children in 2012



Source: UNAIDS (2013). Global Report 2013

Percentage of under 5 deaths due to HIV: The region has not done very well in reducing the percentage of under 5 deaths due to HIV. In Burundi and Uganda the rates remained static at 6% and 7%, respectively; while in the other countries there was only minimal reduction between 2009 and 2012 from 8% to 7% for Kenya and from 6% to 5% for Tanzania (12).

Table 13: Estimated Percentage of under-five deaths due to HIV

Global Plan Country	2009	2012
Burundi	6	6
Kenya	8	7
Uganda	7	7
United Republic of Tanzania	6	5

Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

6.3 Summary on Access to Antiretroviral Treatment in EAC

In the EAC, the number of facilities providing ART services has continued to increase with more lower level health facilities being accredited to provide these services.

An estimated 1,990,000 PLHIV were eligible to ART but the coverage was only 75% implying that there were about half a million PLHIV with un-met need for ART in the EAC or nearly three out of ten PLHIV in need of ART were not getting such treatment.

According to the 2013 WHO guidelines, the number of eligible PLHIV will increase substantially. The increase in resources required indicate that the Partner States have to look for other opportunities within and outside traditional sources of financing to meet this important investment need.

The percentage of people on ART who were retained in care after 12 months of initiation of treatment was 84.1% in Uganda in 2011 while in Kenya it was 76.7% in 2008; in Burundi, the rate of retention was 90% in 2011.

There was an estimated total of 417,700 children in need of ART in East Africa in 2012. However, only 32% of the estimated eligible children were on ART. This clearly indicates that access to pediatric ART in East Africa is unacceptably low compared to that for adults whose coverage is at 75%.

Some of the key challenges in provision of ART include (a) low pediatric ART coverage and low retention of patients on ART (b) inefficient supply chain systems and inadequate referral linkages and systems.

In order to increase access to and uptake of quality ART to the population in the region the following actions are recommended:

EAC

- Advocate better environment to foster local pharmaceutical manufacturing of ARVs and essential HIV and health commodities in the EAC region
- Formulate a policy on pooled procurement of HIV commodities including ARVs in order to benefit from economies of scale
- EAC should work with partner state to formulate a strategy for sustainable financing of HIV and Health service based on the new approach on test and treat
- EAC should ensure implementation of harmonized policy on provision of live vaccine to PLHIV throughout the region

Partner States

- The EAC Partner States should endeavor to institutionalize and provide infrastructure at border posts for enhancing access to health and HIV and AIDS services
- Harmonize and roll out the most up-to-date WHO guidelines as a way of scaling up HIV treatment that is a main component of the regional response for addressing the epidemic
- Strengthen public, private partnership (PPP) in ART services including reporting
- Strengthen linkages/integration across the continuum of response and services to promote uptake of ART including pediatric ART
- Strengthen the supply chain system for drugs and other supplies supporting ART services

CHAPTER 7: AVOIDING TUBERCULOSIS DEATHS AMONG PLHIV

People with HIV associated tuberculosis (TB) have a high risk of mortality thus TB has become a leading cause of death among people living with HIV. Hence, reducing tuberculosis deaths in people living with HIV by 50% by 2015 is among the targets set by the 2011 UN General Assembly. In East Africa, Kenya, Uganda and Tanzania are among the 22 high-burden countries in the world that account for approximately 80% of all new TB cases arising each year.

This chapter presents the TB disease burden in the region and thereafter discusses the HIV infection among TB patients and co-infection of HIV/TB. The chapter also looks into the progress in reducing TB related deaths in East African Community Partner States.

Partner States reviews indicate that Burundi, Rwanda and Kenya are on track to meet the 2011 Political Declaration on reducing deaths due to TB by a half among PLHIV. However, Uganda and Tanzania were found not to be on track in achieving the target of this indicator (Annex I).

7.1 Situation of TB in East Africa

7.1.1 TB Disease Burden Situation

The 2015 global targets for ensuring that there is reduction in TB disease burden are that TB incidence should be falling and that prevalence and death rates should be halved compared with their levels in 1990. This presents a big challenge particularly in the TB high-burden7 countries. 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 in East Africa.

According to the WHO report of 2012 (1), the estimates of the burden of disease caused by TB in the EAC in 2012 are as follows: (a) incident cases range from 78,000 to 120,000 (b) prevalent cases are from 82,000 to 120,000 people and (c) deaths due to TB range from 5,000 to nearly 10,000. Most cases were in Kenya. The HIV positive incident TB cases were less than 50% as is shown in the table below.

Table 14: Estimated burden of disease caused by TB, 2011 (Number in Thousands)

	Population	Mortality	Prevalence	Incidence	HIV Positive Incident TB Cases
Kenya	41,610	9.2	120	120	47
Uganda	34,509	5	63	67	35
Tanzania	46,218	6.4	82	78	30

Source: WHO (2012). Global Tuberculosis Report 2012.

7.1.2 Trend in the Burden of TB

Considerable and intensive efforts have been made to improve TB care and control in the EAC (1,2,3). This has contributed to some extent to the reductions and improvement in the burden of the disease in the East Africa region between 2008 (3) and 2011 (1). The incidence has declined in the three countries and should this trend continue, the international goals will be achieved. In Uganda and Tanzania the number of HIV positive incident TB cases also declined. If this trend is sustained in these countries and the slight increase observed in Kenya is reversed, this indicator will also further improve. The results for mortality and prevalence indicate a reduction for Uganda but an increase for

7 The burden of disease caused by TB can be measured in terms of incidence (defined as the number of new and relapse cases of TB arising in a given time period, usually one year), prevalence (defined as the number of cases of TB at a given point in time) and mortality (defined as the number of deaths caused by TB in a given time period, usually one year).

Kenya and Tanzania. This implies that more work is required if the global targets are to be achieved as envisaged.

Table 15: Change in Burden of Disease caused by TB, 2008-2011 (Numbers in thousands)

Country	Mortality			Prevalence			Incidence			HIV+ve Incident TB Cases		
	2008	2011	Change	2008	2011	Change	2008	2011	Change	2008	2011	Change
Kenya	7	9.2	2.2	71	120	49	127	120	-7	45	47	2
Uganda	8	5	-3	108	63	-45	98	67	-31	59	35	-24
Tanzania	5	6.4	1.4	55	82	27	81	78	-3	47	30	-17

Source: WHO (2010 &2012). Global Tuberculosis Report 2010 & 2012.

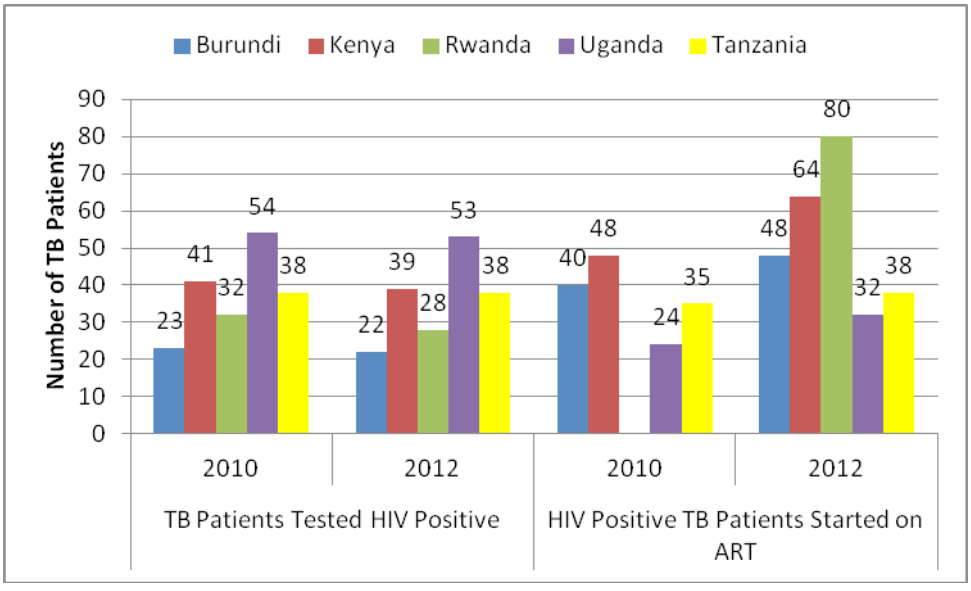
7.2 HIV and TB Infections

7.2.1 HIV Infection among TB Patients

People with HIV-associated TB have a high risk of mortality. This means that by expanding access to ART there can be considerable impact on mortality among HIVpositive TB patients, in addition to reducing the risk of developing TB among people living with HIV who do not have active TB. Thus, WHO in 2010 recommended ART for TB patients regardless of CD4 cell-count because antiretroviral therapy significantly reduces the risk of morbidity and mortality from TB (6).

HIV testing for TB Patients: In 2012, the number of notified TB patients who had a documented HIV test result was more than 70% (1). Rwanda and Kenya recorded 97% and 93% respectively while Tanzania had 88% and Uganda had 80%; Burundi (71%) had the lowest coverage of HIV testing for TB patients in the sub-region.

Figure 23: HIV Testing and Treatment among TB Patients, 2010 and 2012



Source: WHO (2012). Global Tuberculosis Report 2012.

Two key points can be identifed in relation to TB patients who had a documented HIV positive sero-status test result as shown in the left part of the graph above. The first point is that there was a decrease in prevalence of HIV among TB patients between 2010 and 2012 in all the EAC Partner States. The second point is that fewer TB patients in Burundi and Rwanda are HIV positive compared to those in Tanzania, Kenya and Uganda.

Early treatment of HIV among TB patients prevents HIV and TB morbidity, mortality and further transmission. WHO

recommends that all HIVpositive TB patients are eligible for ART irrespective of their CD4 cell-count, the Global Plan to Stop TB 2011-15 also targets providing ART to all TB patients known to be living with HIV by 2015. In this regard, in all the countries of East Africa, there has been considerable improvement in initiation of TB patients that test postive for HIV infection on the ART treament. By 2012, between 30% and 80% of TB patients that tesetd HIV postive were started on ART compared to less than 50% in 2010 as is shown in the figure above.

It is generally known that co-trimoxazole preventive therapy (CPT) is a simple, inexpensive and highly effective intervention that can reduce TB mortality significantly among people living with HIV. In 2012, there was almost universal access to CPT by the identified HIV positive TB patients in the EAC, with very little variation from one Partner State to another. Thus, 93% of the patients in Uganda were on CPT while 97% of those in Kenya and Rwanda received the treatment compared to 95% in Burundi and Tanzania.

7.2.2 Co-infection of HIV/TB and Collaborative TB/HIV activities

To effectively reduce the burden of TB among people living with HIV, WHO recommends a multi-pronged approach known as the "Three I's", namely, intensified case finding, isoniazid preventive therapy and proper infection control to prevent the spread of TB to individuals who are vulnerable to the disease. This is recommended because (a) people living with HIV who are also infected with TB are much more likely to develop TB disease than those who are HIVnegative and (b) antiretroviral therapy significantly reduces the risk of death in patients co-infected with HIV and TB.

In this regard, it is appropriate to state that performance on the majority of TB/HIV collaborative activities in the region has improved as demonstrated by the increased HIV testing among TB patients and increased screening for TB among patients in HIV care. For instance, in Rwanda, the facility-based program reporting in the 2011 National Annual Report on HIV & AIDS 2011 by Ministry of Health showed that 67.2% of patients newly enrolled in care and treatment (20,961 out of 31,199) received screening for tuberculosis during the period July 2010 – June 2011. All 880 patients diagnosed with TB received anti-TB treatment. Indeed, the component of improving TB-HIV integration and management is one of the most successful with 97% of all TB patients registered from July 2010 to June 2011 tested for HIV. The prevalence of HIV was 30% and 98% of all co-infected cases received co-trimoxazole preventive treatment. On the other hand, 65.4% of HIV-positive individuals with newly diagnosed TB received treatment for both HIV and TB in 2011. In Burundi, every person HIV positive must be screened for tuberculosis during first 6 months from the first contact and there is testing for HIV in any case of positive tuberculosis.

Consequently, there has also been an improvement in the Anti-Retroviral Treatment (ART) uptake among TB-HIV co-infected patients (3). In Kenya and Rwanda, the proportion of people living with both HIV and TB disease and received ART was between 51-75% and 76-100% respectively. However, by 2013, Uganda and Tanzania were only able to provide access to ART to less than half of the people that were co-infected with TB and HIV.

Table 16: Access to ART by People Living with both HIV and TB in East Africa

25-50%	51-75%	76-100%
• Uganda • Tanzania	Kenya	• Rwanda

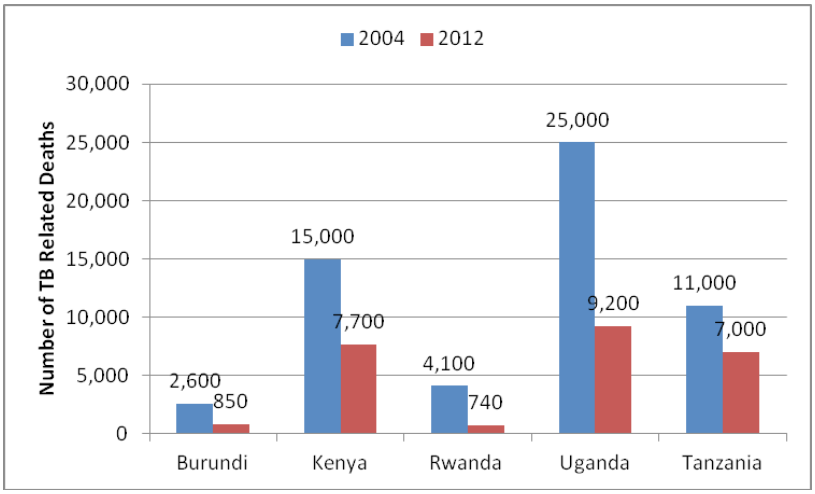
Source: UNAIDS (2013).

Against the above background, however, there is no data on isoniazid preventive therapy (IPT) for those without active TB which has been reported in the Global Tuberculosis Reports of 2011 and 2012. Other challenges include (a) inadequate linkage between TB and HIV program monitoring (b) poor adherence and loss to follow up of patients on treatment resulting in increasing new cases of M/XDR tuberculosis (c) increasing drug resistance among new/old cases but lack of more sensitive diagnostic tools to detect TB and (d) insufficient human resource capacity particularly in management of TB/HIV co-infected patients.

7.2.3 TB-related deaths in the East African Community

There has been considerable progress in efforts to reduce the number of TB related deaths among people living with HIV by 50% by 2015. The estimated number of TB-related deaths among people living with HIV in the East African Community has shown a significant decrease between 2004 and 2012 (3). In Rwanda, there was a reduction of 82% in the number of deaths during this period, compared to 67% and 63% reduction in Burundi and Uganda, respectively. In Kenya and Tanzania, the estimated decline in TB-related deaths among PLHIV was lower, at 49% and 36%, respectively.

Figure 24: Number of TB-related deaths among people living with HIV in EA, 2004 and 2012



Source: UNAIDS (2013). Global Report 2013

7.3 Summary on TB in the East African Community

In East Africa, Kenya, Uganda and Tanzania are among the 22 high-burden countries in the world that account for approximately 80% of all new TB cases arising each year. However, there has been considerable reductions and improvement in the situation between 2008 and 2011. The TB incidence has declined in the three countries and if the trend continues, the international goal will be achieved.

In 2012, the number of notified TB patients who had a documented HIV test result was more than 70%. Early treatment of HIV among TB patients prevents HIV and TB morbidity, mortality and further transmission. By 2012, between 30% and 80% of TB patients that tesetd HIV postive were started on ART compared to less than 50% in 2010.

There is almost universal access to co-trimoxazole preventive therapy (CPT) by the identified HIV positive TB patients in East Africa; CPT is a simple, inexpensive and highly effective intervention that can reduce TB mortality significantly among people living with HIV. There has also been an improvement in the ART uptake among TB-HIV co-infected patients.

The estimated number of TB-related deaths among people living with HIV in East Africa has shown a significant decrease between 2004 and 2012. However, more work is required if the global target of reducing tuberculosis deaths in people living with HIV by 50% by 2015 is to be achieved.

The challenges identified in relation to TB in the region include inadequate linkage between TB and HIV program monitoring, poor adherence and loss to follow up of patients on treatment resulting in increasing new cases of M/XDR tuberculosis.

Hence, the following actions are recommended.

EAC

- Establish mechanism for cross border surveillance and information exchange for MDR TB

Partner States

- Strengthen diagnostics of TB among PLHIV and children through provision of sensitive diagnostic tools in health facilities such as GeneXpert
- Increase screening for TB among HIV patients, provide PLHIV without active TB with isoniazid preventive therapy and put on ART all HIV/TB co-infected patients regardless of their CD4 count
- Strengthen management information systems to track TB drug resistance
- Strengthen human resource and health infrastructure for effective management of MDR TB
- Create mechanism for sustainable financing for TB/HIV interventions to ensure improved resource allocation for TB programme including care among TB/HIV co-infected
- Create more awareness on TB especially among people involved in cross-border movements

CHAPTER 8: GENDER AND HIV RESPONSE

Reducing gender inequality and gender-based violence is not only a perquisite for accelerating sustainable human and economic development, but is also perceived as a significant pathway to effectively responding to the HIV and AIDS epidemic and hence increasing the chance of achieving the targets set in the UN Political Declarations on HIV and AIDS (especially reducing sexual transmission of HIV, eliminating new HIV infections among children, increasing access to ART treatment by PLHIV, avoiding TB deaths, eliminating stigma and discrimination). This is because gender equality and empowerment of women and men increase their abilities to (a) be educated and better equipped to mitigate the impact of HIV and AIDS so that they can enjoy healthier lives (b) have a voice and influence on activities that affect their health, social and economic wellbeing (c) take advantage of opportunities and make informed choices regarding their individual and collective response to HIV and AIDS epidemic.

The UN target is to eliminate gender inequalities and gender-based violence. This chapter discusses the burden of HIV epidemic and the associated attitude and behavior that are related to gender. The factors that predispose one to HIV infection and access to services in relation to gender are also presented.

Partner State reviews indicate that Burundi, Kenya and Rwanda were on track to meet the 2011 Political Declaration on eliminating gender inequalities and sexual violence and increase capacity of women and girls. While Uganda was not on track regarding this indicator, there was no indication on the likelihood of Tanzania achieving the target of this indicator by 2015 (Annex I).

8.1 Burden of HIV Epidemic and Related Diseases

8.1.1 HIV Prevalence, AIDS-related Deaths

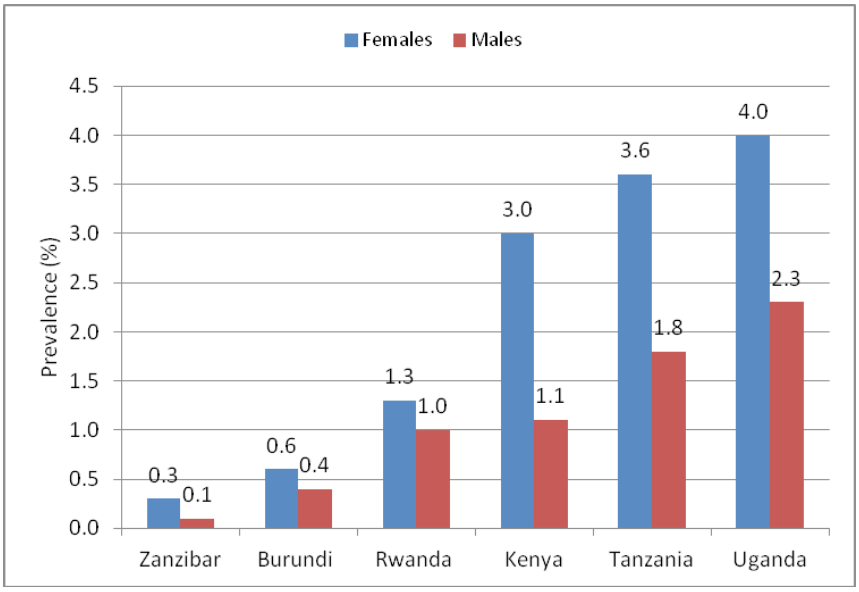
In the EAC Partner States, there is a gender disparity in the prevalence of HIV infection, with women being more affected than men (1, 2, 3, 4, 5). The prevalence among women ranges from 2.4% to 8.3% compared to a range from 1.9% to 6.1% in men in the Partner States where the epidemic is generalized; in Zanzibar, where the epidemic is concentrated, 1.1% of women have HIV compared to 0.9% of men (Table 17).

Table 17: Prevalence of HIV among Women and Men in EAC Partner States

Partner State	Source	Women	Men
Burundi	BDHS-2010	2.4	1.9
Kenya	KAIS-2011	6.9	4.4
Rwanda	RDHS-2010	3.7	2.2
Uganda	UAIS-2011	8.3	6.1
Tanzania	THMIS-2011	6.2	3.8
Zanzibar	THMIS-2011	1.1	0.9

In the EAC, the young people aged 15-24 years constitute more than 50% of the population. Among these young people, there is a gender disparity in HIV prevalence which is similar to that observed in the general population for women and men, with the prevalence being higher among girls than boys. Girls are more likely to be infected than boys in each country, with the rate of infection among them being twice as much as that in their male counterparts (Figure 25) in Kenya, Uganda and Tanzania (6).

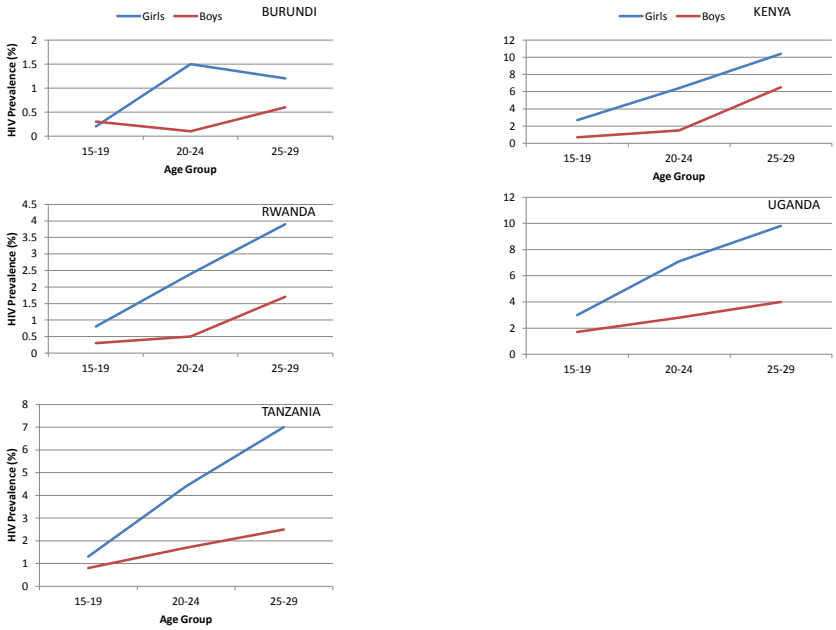
Figure 25: Prevalence of HIV among Boys and Girls 15-24 years in the EAC Partner States



Source: UNAIDS(2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

It is also clear that there is a general increase in HIV infections among the young people as they grow from age 15 into adulthood (1, 2, 3, 4, 5). However, it is also apparent that a larger percentage of girls in each Partner State acquires HIV infection earlier than their counterpart boys. This gender disparity continues into adulthood i.e. 25-29 years of age as is shown (Figure 26).

Figure 26: Trend in HIV Prevalence among 15-29 Age Groups in EAC Partner States



Source: BDHS (2010), KDHS(2010), RDHS (2010), UDHS (2011) and TDHS(2010)

8.1.2 HIV and AIDS-Related Knowledge and Sexual Behaviour

It was noted in Chapter 4 that women in EAC Partner States have less comprehensive knowledge about AIDS than men except in Rwanda. This pattern is the same among youth aged 15-24 years, with 53% of women and 47% of men having comprehensive knowledge on AIDS in Rwanda compared to 45% and 47% in Burundi; 48% and 55% in Kenya;

40% and 47% in Tanzania respectively. In Uganda, 36% of women and 43% of men were found to have comprehensive knowledge (1, 2, 3, 4, 5)

Multiple partnership is lower among women (<4%) than men (3-21%) in the EAC (1, 2, 3, 4, 5). There is a low gender disparity in the use of condoms during sex in multiple relationships. In Burundi and Tanzania it was 14% and 27% respectively for both men and women while in Kenya it was 37% and 32%; in Rwanda 28% and 29%; and in Uganda 28% and 16% respectively for men and women.

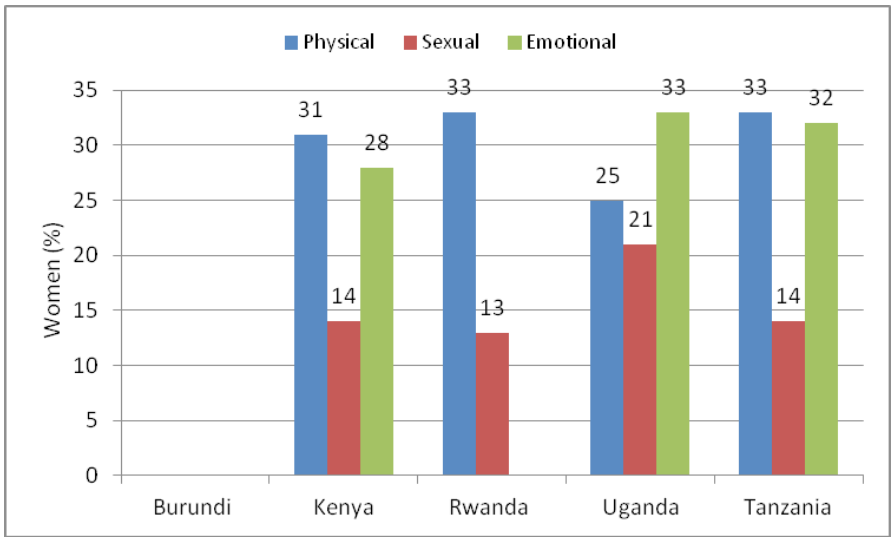
8.2 Factors that Predispose People to HIV Infection according to Gender

8.2.1 Social Factors

There are many harmful socio-cultural practices such as gender inequality and gender-based violence, stigma and discrimination of PLHIV, women and girls, multiple concurrent partnership, polygamy, widow inheritance, early sexual debut etc, that increase the level of vulnerability of women to HIV infection. Some of these are discussed below.

Gender-based violence: Gender based violence is known to increase the risk of HIV infection, particularly in women in whom the violence is associated with social (abuse and inability to seek HIV related services), physical (traumatic injury to the genitals) and psychological dangers (inability to negotiate for sex). In this regard, physical, sexual and emotional spousal violence are quite often experienced by women in married or partnered relationships in the EAC. Thus, more than a tenth of the women in the region have experienced sexual violence in the last 12 months although more than twice as many women have experienced physical and emotional spousal violence in the same period of time (1, 2, 3, 4, 5). In studies carried out in Uganda (7) and South Africa (8), it was found that half of the women who experience gender-based violence are more likely to get HIV infected than their counterparts that have not experienced violence.

Figure 27: Percentage of ever-married women aged 15-49 who have experienced various forms of violence in last 12 months



Source: KDHS 2008-2009, RDHS (2010), UDHS (2011) and TDHS(2010)

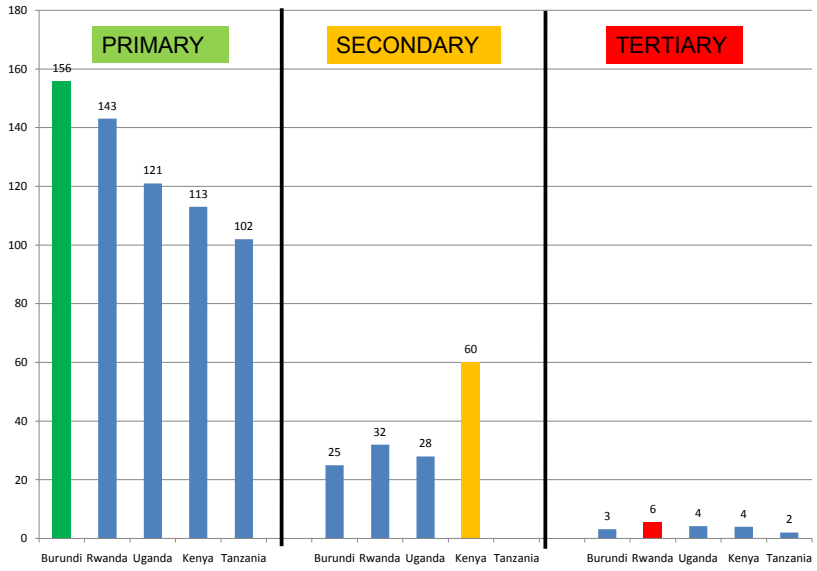
Although the prevalence is lower among the boys than girls, it is also known that the norms on masculinity in the EAC which encourage high risk sexual behavior and discourage health -care seeking behavior tend to increase the vulnerability of the boys to HIV.

Education: Education is a 'social vaccine' to HIV because it offers protection against HIV and AIDS by providing information and skills and developing values that allow young people to make healthy decisions about their lives; increasing young people's connectedness and security; and giving them the possibility to make independent choices

and to be economically productive. In this regard, UNAIDS (9) reported that education reduces the vulnerability of girls in very important ways such as building young women's self-esteem and capacity to act on HIV prevention messages, improving their economic prospects, influencing the power balance in relationships, and affecting their social and sexual networks. Indeed, UNAIDS noted that there is a clear link between school attendance and higher levels of education and later sexual debut with girls who have completed secondary education having a lower risk of HIV infection and practicing safer sex than girls who have only completed primary education.

The Partner States are doing quite well in terms of gross enrollment rates8 in primary education but less so in secondary and tertiary institutions of learning. The rates are more than 100% in primary due to inclusion of over-aged or under-aged pupils and repeaters. According to the most recent demographic and health surveys (1, 2, 3, 4, 5) however, the net attendance ratio in primary tends to be lower for boys than girls, except in Uganda where it is equal for both boys and girls at 81%. In Kenya it is 78% for boys and 80% for girls while it is 86% and 88% in Rwanda and 78% and 82% in Tanzania respectively.

Figure 28: Gross Enrolment Rate in Schools in EAC Partner States, 2002- 2011



Note: Data for most recent year available
Source: UNDP Human Development Report 2013.

Against the above, however, the completion rates vary markedly between girls and boys (10, 11). Except in Rwanda where the rate was higher for girls than boys, the other EAC Partner States have higher rates for boys than girls. Secondly, the median years of schooling, i.e. the number of years spent in school by half the population is more among the men than women in all EAC Partner States (1, 2, 3, 4, 5). As a result of this, literacy is lower among women

8 Gross enrollment rate in primary, secondary and tertiary represents the total enrollment in primary, secondary or tertiary education regardless of age, expressed as a percentage of those eligible among school age population in a given year

than men as is shown in the table below.

Table 18: Completion Rates in Primary Schools, Median Year of Schooling and Level of Literacy in EAC States

Country	Completion by Gendera				Median Year of Schoolingb		Literacyb	
	Year	Both Sexes	Boys	Girls	Women	Men	Women	Men
Burundi	2004	33	40	27	1.6	3.9	62	79
Kenya	2005	94	92	89	7.3	7.8	85	92
Rwanda	2008	54	52	56	3.8	4.1	77	82
Uganda	2009	52	57	48	5.2	5.8	64	78
Tanzania	2007	83	85	81	6.3	6.5	72	82

Sources: aKakande M N (2010). bBDHS (2010), KDHS 2008-09, RDHS (2010), UDHS (2011) and TDHS (2010).

8.2.2 Economic Factors

In the EAC Partner States, men are more likely to be employed than women. According to the demographic and health survey (1, 2, 3, 4, 5) results of the Partner States, while over 80% of men were employed, less than 80% of the women were employed. On the other hand, between 39% and 68% of men were employed in agriculture while nearly up to 90% of the women were employed in the agriculture (see table below).

Table 19: Employment of Women and Men in the EAC Partner States

	Source	Currently Employed		Employed in Agriculture	
		Women	Men	Women	Men
Burundi	BDHS-2010	73	86	89	63
Kenya	KDHS-2009	57	86	39	39
Rwanda	RDHS-2010	73	90	77	68
Uganda	UDHS-2011	69	91	57	55
Tanzania	TDHS-2010	78	84	69	62

The fishing communities are a crucial element in the national economy, and the sector provides meaningful and gainful employment to a wide cross-section of women and men. Studies carried out on fisherfolk around Lake Victoria found that HIV prevalence among this community is more than that in the general population. In Kenya prevalence was at 26.2% compared to 6.3% among the general population (12) while in Uganda (13) and Tanzania (14) it was 22% and 7.6% respectively for fishing communities and 7.2% and 7.5% in the general population. Prevalence was also generally higher among female fisherfolk. For instance, in Kenya, the prevalence was 28% among women and 25% among male.

Poverty: It is generally recognized that in low income countries, AIDS deepens poverty while at the same time there is an increased likelihood of persons living in poverty to become infected. Poverty limits access to services and also increases the likelihood that poor people will engage in early sex and depend on commercial, transactional and cross-generational sexual relationships. On the other hand, many affected people have their economic status lowered because of decreased income and increased demands; and yet many lack the skills or capital for income generation. In East Africa, families and households taking care of orphans are overwhelmed with needs of the OVC that they support. Most people in the region are employed in the informal sector.

In the region, however, HIV prevalence is positively correlated with wealth (1, 2, 3, 4, 5). The people in the lowest quintile have less infection while those in the highest quartile have the highest prevalence too.

Table 20: HIV Prevalence in Partner States by Wealth Quintile in East Africa Partner States

Wealth Quintile	East African Partner State				
	Burundi	Kenya	Rwanda	Uganda	Tanzania
Lowest	1.2	4.6	2.7	6.3	4.0
Middle	1.2	5.6	2.1	6.9	5.0
Highest	2.7	7.2	5.1	8.2	6.6

Source : BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011), THMIS (2011)

8.2.3 Legal Factors

In the region, a gender mainstreaming tool kit was developed and adopted by the LVBC Sectoral Council in January 2011, and was accordingly published and disseminated in all the Partner States. The EAC Secretariat in collaboration with the Eastern Africa National Networks of AIDS Service Organizations (EANNASO) and the East African Health Platform (EAHP) has also carried out a comprehensive Analysis of the HIV and AIDS Legislation, Bills, Policies and Strategies in the East African Community in order to identify strategic gaps and challenges in the domestic legal and regulatory frameworks of Partner States, in relation to the EAC HIV and AIDS Prevention and Management Bill.

Some legal frameworks in East African countries are likely to impede behavior change, disclosure and access to HIV related services. In the region, there are some proposed laws that could inadvertently drive the epidemic. For instance, the HIV and AIDS Prevention and Control Bill 2010 that is being debated by Uganda's Parliament if enacted [may] reverse some of the gains made in HIV prevention. Though the Bill seeks to create a legal framework for HIV and AIDS prevention and control and to promote access to health-care services by prohibiting discrimination, it s also criminalizes the intentional and/or reckless transmission of HIV to another person and sets penalties.

Throughout East Africa, the criminalization of sex work renders women engaged in it vulnerable to SGBV, exploitation, and leaves them no choice but to operate underground. It also weakens their negotiating power for protected sex. Homosexual relationship is also criminal especially in Uganda. The Anti-Homosexuality Act assented to by the President of Uganda (annulled in August 2014) criminalized sexual intercourse between same sex partners and also provided for a sentence of life imprisonment for anyone convicted of homosexuality which covers both gays and lesbians.

8.3 Access to HIV Services and Gender

8.3.1 HCT

Women tend to have greater access to HCT compared to men. In this regard, it was noted in Chapter 4 that in all the Partner States more women than men go for HIV testing. This is partly because counseling and testing for HIV are also offered at the ante-natal clinics that are predominantly attended to by pregnant women. Among youth aged 15-24 years, girls are also more likely to take tests for HIV and get results than the boys (1, 2, 3, 4, 5). This gives the women greater opportunity to enjoy the benefits of knowing one's HIV status as a result of taking the test.

8.3.2 Health Insurance

Medical insurance provides ready access to care and treatment that may save the life and/or well-being of those enrolled on the health insurance scheme. This can be particularly important in provision of peace of mind that a person affected or infected by HIV epidemic may require. In the region, health insurance is provided through many arrangements including mutual health organizations or community-based insurance, employer-based insurance, and privately purchased commercial insurance.

Based on the findings from the demographic and health surveys (1, 2, 3, 4, 5), women in the EAC tend to be less covered with health insurance than the men. It is only in Rwanda where the opposite is true as is shown in the table below.

Table 21: Coverage (%) of Health Insurance in the EAC

Partner State	Source	Gender	
		Women	Men
Burundi	BDHS-2010	10	11
Kenya	KDHS-2009	13	23
Rwanda	RDHS-2010	71	66
Uganda	UDHS-2011	1	2
Tanzania	TDHS-2010	6	6

8.4 Summary on Gender and HIV Response

Women in the region continue to experience numerous forms of gender inequality and gender based violence. Nearly 20% of the women experience sexual violence and more than twice as many women have ever experienced physical and emotional spousal violence. On the other hand, there are legal barriers to same-sex behavior including sex between men and among women. Commercial sexual activities are also illegal in many countries of the EAC
Education is known as a social vaccine for responding to HIV. In this regard, considerable effort has been made in increasing the gross enrollment rate in primary education institutions of learning across the region. However, there is a lot of gender disparity in medial year of education and level of literacy to the disadvantage of women.

A key challenge in the elimination of gender inequality was noted to be related to structural, economic and social factors that present obstacles to effective HIV prevention especially to women and young people in the region.

In order to address the above and reduce gender inequality. the following actions are recommended:

EAC

- Advocate and harmonize regional laws and policies that enhance access of HIV services without discrimination of marginalized populations

Partner States

- Address social and structural factors that predispose women to HIV infection, particularly those related to gender based violence
- Review laws and policies that negatively impact on the national response to HIV e.g. those that criminalize commercial sex work and HIV transmission
- Promote strategies that (a) increase access to HIV and other health services by women (b) keep young people in schools (c) empower women socially and economically

CHAPTER 9: STIGMA AND DISCRIMINATION

Stigma and discrimination are among the contextual risk factors that drive the HIV and AIDS epidemic in the EAC. Hence, stigma, discrimination and violations of other human rights are major barriers to effective national responses to HIV in the region. Thus, one of the UN Political Declarations on HIV and AIDS is on elimination of stigma and discrimination.

In this chapter, a presentation is made on the attitude of the general population to PLHIV in the region. The results of the Stigma Index studies carried out by networks of PLHIV are thereafter presented.

Partner State reviews indicate that Burundi, Kenya and Uganda were on track to meet the 2011 Political Declaration on eliminating stigma and discrimination among PLHIV. However, Rwanda and Tanzania were not likely to meet the target set for this indicator (Annex I).

9.1 Attitude towards PLHIV

There is an accepting attitude towards PLHIV by the population in the EAC (1, 2, 3, 4, 5). Over nine out of ten men and women in the EAC say that they can take care of AIDS patients. Similarly, over two out of three women and men indicated that they can buy groceries from a shopkeeper with AIDS. Likewise, over four out of five people in the region are willing to allow a teacher with AIDS to continue teaching their children. The EAC Partner States need to build on these positive attitudes in order to address the stigma and discrimination and human rights challenges faced by PLHIV.

Table 22: Attitude of General Population (%) towards People Living with HIV in East African Community Partner States, 2012

Partner State	Care for AIDS Patient	Buy from Shopkeeper with AIDS	Allow teacher with AIDS to continue teaching
Women			
Burundi	76	70	73
Kenya	90	68	76
Rwanda	96	84	87
Uganda	92	72	78
Tanzania	93	63	84
Men			
Burundi	88	85	83
Kenya	94	80	80
Rwanda	97	90	89
Uganda	93	80	80
Tanzania	96	71	83

Source: BDHS (2010), KAIS(2011), RDHS (2010), UAIS (2011) and THMIS (2011).

9.2 Stigma and Discrimination Experienced by PLHIV

PLHIV in the EAC experience various forms of stigma and discrimination including social stigma and discrimination, internalized stigma, physical and verbal violence and institutional stigma and discrimination. This is based on the evidence from the Stigma Index studies carried in Uganda (6) and Rwanda (7) that are discussed further below; in Burundi, the Stigma Index Study is still on-going while the Kenya (8) report has not been verified at national level.

9.2.1 Social Stigma and Discrimination

The family and local community are supposed to provide a loving and caring environment but PLHIV still experience social stigma and discrimination in these settings. In Rwanda 22% of PLHIV were excluded from family events, this was also experienced by 16% of PLHIV in Uganda. In this regard, a study (9) in Uganda reported that families were hesitant about spending money on medical and nonmedical needs of PLHIV, because of fear they may not recuperate completely. Another common practice within families reported in the study was the exclusion of a PLHIV

in family discussions and decision-making processes. Children infected with HIV were also reported to be denied the opportunity to attain education because education was seen as an investment and families are not willing to invest in the education of children whose chances of surviving to adulthood hang in the balance.

9.2.2 Internalized Stigma

Internalized stigma also called self--stigma or felt stigma, occurs when people living with HIV view themselves as guilty or responsible for their situation. Self-directed stigma is still rife in the EAC. In Uganda (6) half of the PLHIV indicated that they feel ashamed of being infected with HIV; in Rwanda 45% of PLHIV do the same. Indeed, over half of PLHIV in Uganda (55%) feel suicidal regarding their HIV positive status while 14% of PLHIV have similar experience in Rwanda (7). All this implies that people living with HIV need more counseling and support to accept their status and live positively.

Verbal assault and physical assaults are the two main forms of gender-based violence experienced by PLHIV. Verbal stigma may include the use of derogatory names and terms when referring to PLHIV such as "moving skeleton," "walking corpse," and "keys to the mortuary" among many others. In Rwanda, nearly about 54% of PLHIV reported having experienced verbal assaults while in Uganda (6) about 35% did so. In addition to this, physical assault that may be more damaging is not very common in the EAC, with about 10% of PLHIV in Uganda (6) and 20% of those in Rwanda (7) having experienced it.

9.2.3 Institutional Stigma and Discrimination

In the EAC (6, 7), HIV and AIDS stigma and discrimination is experienced by PLHIV in various institutional settings such as the workplace, schools and health units. At the workplace, institutional stigma and discrimination that PLHIV experience include (a) enacted stigma when work colleagues display negative attitudes towards PLHIV and (b) discrimination when PLHIV are sent away from work, or denied opportunities for career growth at the workplace by the employer who may be skeptical about the ability of PLHIV to continue work or may wish to avoid the medical and absenteeism costs associated with an employee who is a PLHIV. In Rwanda, more than one in four PLHIV were denied employment opportunity due to their HIV positive status while in Uganda this occurred among one in ten PLHIV. On the other hand, PLHIV also lost jobs or income due to their sero-status. This was three times as likely to occur in Rwanda (7) than Uganda (6) where the proportion of PLHIV experiencing it in the 12 months before the Stigma Index study was 65% for Rwanda and 22% for Uganda.

9.3 Legal Redress to Stigma and Discrimination

9.3.1 Policies on Stigma and Discrimination

Awareness of the 2001 Declaration of Commitment on HIV (10) and knowledge of national laws (e.g. HIV and AIDS Prevention and Control laws) and policies that are intended to provide some protection of the rights of people living with HIV, as well as violations of rights experienced in various settings are critical in the national response. In particular, the PLHIV need to be conversant with these provisions so that they are adequately empowered to take the necessary actions as the need arises. In the EAC, PLHIV are not adequately informed about legal provisions to protect themselves against stigma and discrimination. On the other hand, it was also noted that many legal provisions addressing stigma and discrimination are not adequately enforced in many Partner States.

The Stigma Index studies for Rwanda (7) and Uganda (6) indicate that 53% of PLHIV in Rwanda and 47% of those in Uganda have heard of the Declaration of Commitment on HIV and AIDS which protects the rights of people living with HIV. However, only 28% of PLHIV in Rwanda have heard about the Rwandan law which protects the rights of PLHIV compared to 42% in Uganda (6) who are aware of the National HIV/AIDS policy that protects PLHIV.

9.3.2 Strategic Plans, Stigma and Discrimination

The EAC Partner States have committed to protect the human rights of people living with HIV, as well as the rights of women, children, and members of vulnerable and key populations in the context of HIV. This not only reduces the personal suffering that can be associated with HIV, but also helps to create social and legal environments that encourage people to take up and use HIV services. Thus, the Partner States integrated stigma and discrimination in their national strategic plans for responding to the HIV and AIDS epidemic. In Uganda, there is a strategic action on stigma and discrimination; it aims to implement interventions that reduce stigma and discrimination in order to mitigate underlying social, culture, gender and other factors that drive the HIV epidemic. In Kenya there is provision for workplace policy review, organizational strengthening, provision of funding, stigma reduction, referrals and networking. There is more elaboration in the NSP of Rwanda and Tanzania regarding stigma and discrimination. In Rwanda, one outcome is on reduction of stigma and discrimination of PLHIV and OVC in the community as one of the outcomes with outputs that include; the rights of people infected and/or affected by HIV are assured in legal framework; people living with HIV and orphans and vulnerable children have access to legal aid services; increased acceptance of persons infected/affected in the community; and increased self-acceptance of people infected and/or affected by HIV. In the case of Tanzania, there are three objectives for addressing stigma, denial and discrimination. They are (a) safeguard human rights of PLHIV and their families through non-discriminatory attitudes in their communities and through improved access to user-friendly and gender responsive HIV services (b) promote cultural practices that enhance transfer of knowledge and skills of sexual and reproductive health issues and (c) promote high level leadership (political, traditional and community-based).

9.4 Summary on Stigma, Discrimination and the Law

Although there is an accepting attitude towards people living with HIV by the general population in the East African Community Partner States, PLHIV in the region experience various forms of stigma and discrimination. At the family and institutional levels, PLHIV experience stigma and discrimination. The PLHIV also experience internalized stigma. However, despite the high level of knowledge about HIV/AIDS, there is still some negative attitude towards acceptance of PLHIV. There are also many social and cultural barriers that aggravate the practice and impact of stigma and discrimination and affect disclosure, access to services and safe behavior among PLHIV, CSWs, MSM, OVCs, PWDs and older persons.

In order to address the issue of stigma and discrimination, the following actions are recommended:

Partner States

- Integrate HIV stigma and discrimination reduction messaging in prevention, care and treatment interventions
- Strengthen and scale-up interventions that address reduction of practice and impact on stigma and discrimination among PLHIV, CSWs, MSM, OVCs etc

CHAPTER 10: SUPPORT FOR FAMILIES AND CHILDREN AFFECTED BY HIV AND AIDS

The impact of HIV and AIDS is first and foremost felt at the family and community levels before the sub-national and national levels. At the family level, morbidity erodes the capacity of the family to take care of its basic requirements including food, shelter and medical requirements. Mortality of adults in the family unit deprives the unit of the parents and/or bread earners while leaving many orphans behind. Indeed, most of the orphans in the region are due to AIDS deaths.

This chapter discuses the general trend in the number of orphans caused by AIDS in the East African Community region. The type of support given to orphans and vulnerable children as well as strategies and policies adopted by the individual countries for addressing families affected by HIV and AIDS and OVC is also presented. Lastly, specific interventions that have been effective for supporting families and children affected by HIV and AIDS are discussed in this chapter.

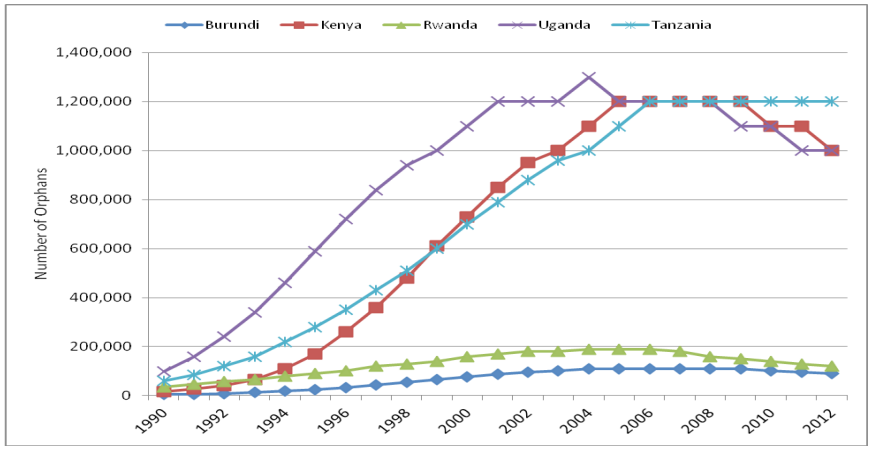
10.1 Orphans and Vulnerable Children in the Region

10.1.1 Orphans and Vulnerable Children

The number of orphans and vulnerable children is decreasing but still very high. The EAC is home to nearly 5 million people living with HIV but is also home to nearly 4 million orphans (1). AIDS is one of the leading causes of death among adults aged 15–59, and as one consequence, most of children orphaned are as a result of having lost one or both parents to AIDS.

The number of orphans in the region rose tremendously throughout the 1990s and early 2000s from a low estimation of 216,000 in 1990 to 3.8 million in 2005. During the period, most of the infected adult parents succumbed to the disease and died due to AIDS-related sicknesses as there was no affordable treatment available in the region. Indeed, in 2005 the percentage of children who were orphans in Burundi and Kenya were 13% while those in Rwanda, Uganda and Tanzania were 16%, 14% and 12% respectively. The number of children orphaned by AIDS as a proportion of all orphans was 21% for Burundi and 26% for Rwanda. On the other hand, over 40% of the orphans were due to AIDS deaths; for instance the percentage in Kenya was 46%, Uganda was 45% and Tanzania was 44% (2).

Figure 29: Trend in the Number of Orphans in East Africa, 1990-2012



Source: UNAIDS (2012). UNAIDS Report on the Global AIDS Epidemic - 2013

From 2005 to date when there was a massive scaling up of ART provision, the number of deaths among adults in the region declined. Accordingly, the number of orphans also declined. Consequently, in 2012, there were only nearly 3.4

million orphans in the region with about 29% each in Kenya and Uganda and 35% in Tanzania. Burundi and Rwanda had only about 6% of the orphans in the region. It is clear and significant to note that the variation in distribution of orphans in the region also mimics the variation in HIV prevalence thus underscoring the role that the epidemic plays in orphaning levels.

The age distribution of children who are orphans is fairly consistent across countries. UNICEF estimated that about 5% of children aged 0-5 years were orphans while 15% and 25% of children in the age groups 6-11 years and 12-17 respectively were also orphans. Indeed, almost half of all orphans and two thirds of double orphans were estimated to be adolescents aged 12–17 (2). This age variation among orphans has significant implications for planning appropriate response that meets their needs because of the varying developmental stages they find themselves in. For instance, older orphans may be at risk of missing out on education, being subjected to exploitative labor, and being exposed to HIV and other sexually transmitted infections. On the other hand, the youngest orphans – although making up a smaller percentage of all orphans are the least resilient and have the greatest need for physical care and nurturing.

10.1.2 Families Supporting OVC

One in three households in the region are lived in by foster and/or orphaned children9. In Uganda the proportion of such households was 32.9% while that for Tanzania was 31.3%; in Rwanda it was 30.2%. These households experience the immediate impact of HIV and AIDS, because apart from taking care of the orphans, the families would have been the main caregivers for the sick and incurred AIDS-related financial hardships and loss of income. Indeed, many of these families assume this responsibility with little public support yet the capacities of these families, households and communities are increasingly strained and overwhelmed in meeting the growing need for looking after and caring of the OVC. On the other hand, because the OVC are dispersed across these local communities and families they and their conditions are not clearly visible to government and policy makers. Consequently, in most of the countries in the region, these extended families and communities continue to shoulder the strain, largely with very limited public assistance. It is therefore apparent that the burden of OVC has enormous impact on the traditional social networks in the region making it difficult for communities to cope with both the large number of HIV infected and affected families and the number of orphans and other vulnerable children. Indeed, the large number of vulnerable children needing care and support is far more than the families and existing institutions can cope with.

10.2 Response to OVC and Families affected by HIV and AIDS

Orphans and vulnerable children (OVC) are directly affected by the epidemic. They are affected because (a) they are living at high risk of HIV infection; (b) they are living with chronically ill parents, adults or siblings and being required to work or put their education on hold as they take on household chores and care-giving responsibilities at a very early age; (c) their households are experiencing greater poverty because of HIV-related morbidity and mortality; (d) they are being subjected to stigma and discrimination because of their association with a person living with HIV. OVC may also be indirectly affected when their communities, and the services these communities provide, are strained by the consequences of the AIDS epidemic.

10.2.1 Strategies and Policies Addressing OVC and Families affected by HIV and AIDS

In the national response within the region, support to OVC and families affected by HIV and AIDS is a major part of impact mitigation of HIV and AIDS epidemic. In this regard, the issue of orphans and vulnerable children as well as HIV and AIDS infected and affected groups in the region has been given attention in the respective NSP. For instance, in order to comprehensively address the issue of orphans and vulnerable groups in Kenya, through the KNSAP-III the country has committed to establish a consolidated Social Protection Fund for orphaned and vulnerable children as well as other socially disadvantaged persons. In Rwanda there is a planned strategy in which (a) people infected/ affected by HIV (including child headed households) will have their economic opportunities and social protection improved (b) social and economic protection will be provided for orphans and vulnerable children and (c) stigma and

9 Foster children are children under age 18 living in households with neither their mother nor their father present. Orphans are children with one or both parents dead. Foster children and orphans are of concern because they may be neglected or exploited if no parent is present

discrimination of PLHIV and OVC in the community will be reduced. In Tanzania, goal 4 of the HIV national strategic plan, is to improve the quality of life of PLHIV and those affected by HIV and AIDS, including orphans and other vulnerable children. Goal 3 of NSP aims to (a) to scale up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV (b) to empower HIV affected households and most vulnerable groups with livelihood skills and opportunity to cope with socio-economic demands and (c) to scale up coverage of a comprehensive social support and protection package to most vulnerable PLHIV and other affected groups. Uganda through the NSP has committed to (a) scaling up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV (b) scaling up delivery of comprehensive quality psychosocial services to PLHIV, affected households and persons most vulnerable to exposure to HIV; and (c) scaling up coverage of a comprehensive social support and protection package to most vulnerable PLHIV and other effected groups. Regarding OVCs, in particular, the country has also identified eight core programme areas for OVC interventions, namely, socio-economic support, psychosocial support, health care services, care and support, food security and nutrition services, child protection, legal support, and education support. Although steps have been taken to include OVCs in the national HIV and AIDS strategic plans and other sector plans, resource allocation, implementation and coverage of such plans remain limited.

A number of policies have also been put in place in order to support the national efforts for addressing the issues pertaining to OVCs and families affected and infected by HIV. In Kenya there is an OVC Policy and a revised National Plan of Action for OVC, 2007-2010 while in Uganda there is also a National OVC Policy (2004) (3) that recognizes HIV and AIDS among the top causes of orphanage and a National Strategic Programme Plan for Orphans and other Vulnerable Children (NSPPI 2). The NSP in Rwanda noted that important steps have been made in the establishment of an enabling environment for legal and policy framework for the protection of rights of people living with HIV and AIDS and OVCs and for prevention and prosecution of sexual violence. Even then, there is policy gap on how to deal with the reproductive and counselling needs of OVC living with HIV.

10.2.2 Effective Interventions for Addressing Families affected by HIV and AIDS and OVC

Education of OVC is of paramount importance. Access to education is considered an "essential service" and is included among the key components of national responses to guarantee orphans access to services on an equal basis with other children. To assess whether orphans are educationally disadvantaged in relation to other children, the ratio of the percentage with both parents deceased to the percentage with both parents alive and living with a parent is used. Thus it was found that school attendance ratio varies only slightly in the Partner States. While for Uganda (4) the ratio is 0.87 between the percentage of children with both parents deceased and the percentage of children with both parents alive and living with a parent, for Rwanda (5) and Tanzania (6) it is 0.91 and 0.9 respectively. There is, however, low retention of OVC in formal/informal training due to lack of non-tuition dues, scholastic materials and lack of food plus startup kits.

Cash transfer is proving effective in addressing problems of families affected by HIV and AIDS and OVC. Among OVC and HIV and AIDS affected families, food and nutrition insecurity increases susceptibility to HIV exposure and infection and lower resiliency to AIDS impacts, while HIV and AIDS intensifies vulnerability to food and nutrition insecurity. Poverty and food and nutrition insecurity can accelerate the spread of HIV by increasing exposure to the virus and heightening the risk of infection if exposure occurs. To address this, conditional and unconditional cash transfer programs have been implemented in East Africa and many other countries across the world. These transfers help to (i) meet current basic needs of adults and children such as food and clothing (ii) contribute to development processes by enabling or encouraging investment in assets that increase people's chances of breaking out of poverty over the long term and (iii) increase women's autonomy and capacities, or strengthening capacities of local organizations.

Conditional cash transfer programs have demonstrated large and statistically significant impacts on poverty and on education, health, and nutrition outcomes, mainly for children. For instance, a study in Kenya and other countries (7) comparing people receiving food aid and ARVs with people on ARVs alone found that the benefits of the food were substantial with respect to improved health, strength, and other measures of well-being. In Malawi a study provided monetary incentives to people to pick up their HIV test results, taking into account distance to results centers, and found that even a small incentive doubled the percentage of participants who learned their results. In addition, sexually

active individuals who learned their results and tested positive were three times more likely to purchase condoms two months later. On the other hand, cash transfer programs, whether UCT or CCT programs, have improved food consumption and dietary diversity and, in some cases, nutritional status. These outcomes are of critical importance to HIV-affected households because they can mitigate the impacts of HIV and maintain an improved quality of life as well as prevent transmission of the disease. However, in all the Partner States, there are limited resources for scaling-up tested interventions addressing the economic and other needs of the OVC and families affected by HIV and AIDS.

Some of the common challenges experienced in the region in the provision of support to families and OVC include (a) low retention of OVC in formal/informal training due to lack of non-tuition dues, scholastic materials and lack of food plus start up kits (b) limited provision of legal services to OVC and families affected by HIV and AIDS (c) limited resources for provision of various needs of the OVC and families affected by HIV and AIDS. The public/state and community structures for protection of OVC and supporting their families are also inadequate.

10.3 Summary on Support to Families and Orphans and Vulnerable Children in the Region

The region is home to nearly 5 million people living with HIV but is also home to nearly 4 million orphans and vulnerable children, although the number of OVC has been decreasing since 2005.

One in three households are in support of foster and/or orphaned children but because the OVC are dispersed across these numerous local communities and families, they and their conditions are not clearly visible to government and policy makers. This leaves these extended families and communities to shoulder the strain of catering for the OVC, largely with very limited public assistance.

The issue of orphans and vulnerable children as well as HIV and AIDS infected and affected families and communities in the region has been given attention in the respective national strategic plans. Many countries also have produced policies and investment plans specifically addressing the plight of OVC. However, implementation of such policies and plans are slow.

Education of OVC is of paramount importance as it is an "essential service" which guarantees OVC's access to other services now and in the future on an equal basis with other children. The EAC Partner States have a school attendance ratio of 0.9 between orphans and non-orphans.

Another effective intervention for addressing families affected by HIV and AIDS and OVC is the use of a cash transfer approach. It has been demonstrated that unconditional or conditional cash transfer helps to (i) meet current basic needs of adults and children such as food and clothing (ii) contribute to development processes by enabling or encouraging investment in assets that increase people's chances of breaking out of poverty over the long term and (iii) increase women's autonomy and capacities, or strengthening capacities of local organizations.

One of the key challenges in addressing the OVCs and affected families is that many extended and other families supporting OVC are overstretched with the burden of OVC making it difficult for the social and economic needs (including educational and informal training needs) of the OVCs to be adequately addressed. There are also challenges in legal service provision for OVC and families affected by HIV and AIDS.

In order to continue with the necessary support to the OVC and the affected families the following need to be addressed:

EAC

- Advocate social protection programmes for families and children affected by HIV and AIDS

Member States

- Scale up the minimum package for OVC support including cash transfer approach
- Support provision of legal services to OVC and their families

CHAPTER 11: FINANCING HIV AND AIDS RESPONSE IN THE REGION

Provision of adequate resources in a timely manner is one of the key components of a national response to HIV and AIDS which should be accompanied with effective and efficient allocation and utilization of the resources. However, in most cases, resources for implementing the national strategic plans are inadequate. Hence, one of the targets of the 2011 UN Political Declarations on HIV and AIDS was on closing the global AIDS resource gap by 2015 and reaching annual global investment of US$ 22–24 billion in low- and middle-income countries.

In this last chapter of the report, the trend in HIV budgeting as captured in the national strategic plans is presented together with the associated sources of funding. The typical sources included public sector financing through the budget and non-public sector funding. The latter mobilizes funding from external AIDS development partners and also internally from the population and business communities. The chapter also presents information on resources allocation and utilization with comparison being made between countries in the EAC and some in Africa. The last topic dealt with in the chapter is on resource mobilization for bridging the gap in resource need. This includes efforts for improving efficiency in use of existing resources and mobilizing resources using the investment framework developed by UNAIDS and by ensuring the strategic allocation of available resources.

Partner State reviews indicate only Kenya was on track to meet the 2011 Political Declaration on closing the national AIDS resource gap. While Burundi had no data on this indicator, Rwanda, Uganda and Tanzania were not on track regarding achieving the target for this indicator (Annex I).

11.1 Total Funding for HIV and AIDS

Total budgets and actual funding for HIV and AIDS response in the region has continued to increase in the Partner States. This signifies greater political commitment in the fight against the epidemic. However, a considerable gap remains between the projected costs of the response and the actual resources mobilized, particularly at the time of concluding the planning.

11.1.1 Trend in HIV and AIDS Budgeting

There has been a consistent increase in the budgetary projections for HIV and AIDS in the East African Community countries during the last five years as captured in the respective national strategic plans (1, 2, 3, 4, 5, 6, 7, 8). Kenya projected an increase of 57% in its budget for HIV and AIDS between 2009/10 and 2012/13, Rwanda (28%), and Uganda's (120%) during the same period. These increases were against the overall budgets that ranged from about $200 million for Rwanda in 2009 to over $1 billion for Kenya in 2012. Kenya10 had the largest projected investment in HIV at over $3.5 billion while Uganda had $2 billion and Rwanda just $1b over the four years. These increasing budgetary projections for implementation of the national strategic plans represent (a) evidence in recognition of the importance that the epidemic plays in the region (b) greater political commitment to fight HIV and AIDS (c) regional experience in developing a minimum resource mobilization tool for supporting the national response. By pointing out the gap between the projected cost estimates and the resources mobilized at the time the planning ended, the platforms for resource mobilization and implementation were set although the translation of the plans and budgets to reality in all the Partner States remains problematic.

10 The annual increases for Kenya has been mainly due to proposed scale-up in interventions targeting communities, MARPs, HCT, PMTCT, ARV therapy, Nutritional Support, Treatment of Opportunistic Infections, OVC, HIV Programme Management and M&E.

Table 23: Projected Cost Estimates (US $) for Implementation of Partner State National Strategic Plan for HIV and AIDS 2009-2013

Partner State	2009/10	2010/11	2011/12	2012/13	TOTAL
PROJECTED COST OF NATIONAL STRATEGIC PLAN					
Burundi	28	24	30	61	143
Kenya	671	833	998	1,054	3,556
Rwanda	206	221	243	263	934
Uganda	347	402	585	765	2,099
Tanzania					
FUNDING GAP					
Burundi					
Kenya	261	350	487	569	1,667
Rwanda	70.5	95.4	118.4	140.5	424.8
Uganda	13	13.4	194.7	345	566
Tanzania					

Source: CNLS Burundi (2012), NACC (2009), UAC (2007), CNLS Rwanda (2009).

In the four year period, there was an unmet need in funding of between $425m and $1.7b across the East African countries. Kenya and Uganda had a funding deficit of about over 45% while Rwanda recorded a 27% shortfall between the planned and mobilized resources covering the four years. This shows that at all times, there will be need for increasing efforts towards resource mobilization to fund the regional response.

11.1.2 Trend in HIV and AIDS Financing

There is limited information on the spending on HIV and AIDS in the various countries of the EAC. From the NASA studies carried out in the region (12, 15, 16) there has been (a) a varying amount of money spent by respective countries and, indeed, all of them have had some increase in overall spending on the epidemic using evidence from Kenya and Uganda. Kenya spent US$307.69 million (KES.21.81 billion) spent on HIV and AIDS response in 2006/07 and another US$ 361.86 million (KES. 23.86 billion) in 2007/08, representing an 18% increase for Kenya. In comparison, a total of $586.6 million (1,109 billion UGX) was spent in Uganda on HIV and AIDS control activities in 2008/09 and 579.7 million US $ (1,167 billion UGX) in 2009/10. This reflects 5% increase in shilling terms but a small decrease of 1% in US dollar terms implying no appreciable difference in the total level of expenditure between the 2 years.

11.2 Sources of Funding for HIV and AIDS

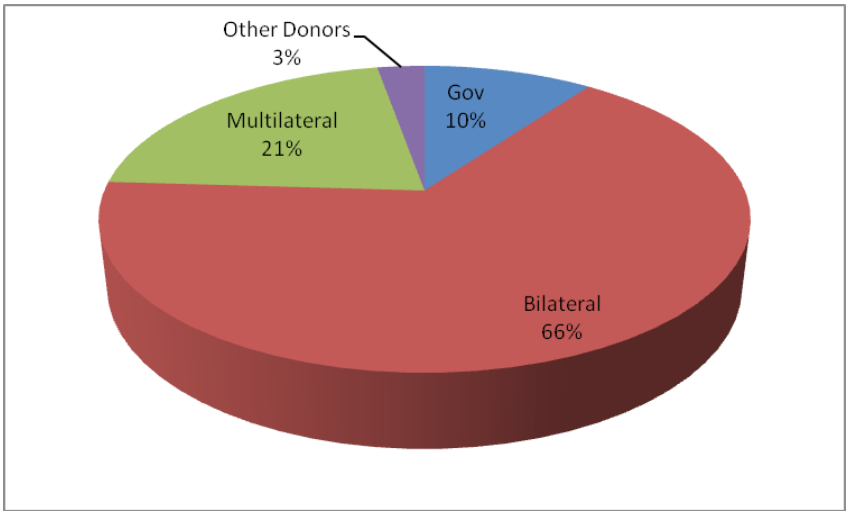
It is the role of government to provide services including those for health to the population. Governments in the region have been able to do this by integrating HIV and AIDS in their budgetary processes. In addition to this, development partners have provided resources to the Partner States through on-budget and off-budget support.

11.2.1 Government Financing of the Epidemic

Domestic investment in HIV and AIDS has increased but remains lower than the contribution from development partners. UNAIDS (11) has noted that the EAC Partner States generally increased their domestic investments between 2006 and 2011. In particular, Tanzania was reported to have fallen in the bracket of countries that had a percentage increase between 50-100% while Uganda, Kenya and Rwanda were in the more than 100% bracket.

There was no consistent data on details of resources utilized for HIV and AIDS in the region. Thus, only data from Rwanda 2009/10 (12), Uganda 2009/10 (13) and Burundi 2009 (14) has been analyzed and reported here. In the two countries the data analyzed shows that a total of $0.5 billion was used by the three countries. While government contribution was only 10% of the total expenditure, bilateral aid (66%) was over six times that provided by government. Multilateral support was modest at only 21%. In Burundi, it was noted that the Government mobilizes funds that are used to finance public and civil society organizations especially through performance-based financing.

Figure 30: Distribution of resources for HIV and AIDS in some Partner States



Source : Rwanda (2012), Mukobe & Kavuma (2011) and Burundi (2010).

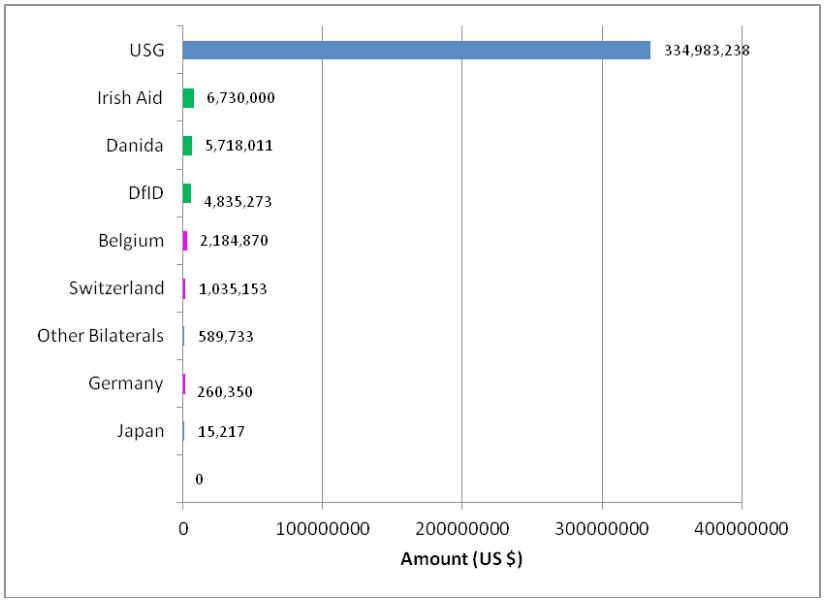
An assessment by UNAIDS (15) based on NASA and UNGASS data indicated that all the five EAC Partner States have a donor dependency of over 50%. Tanzania fell within the 50-74% external resource dependency bracket while Burundi, Kenya, Rwanda and Uganda were ranked within the 75-100% bracket. For comparison, Angola, Lesotho and Namibia were in the 25-49% dependency group while South Africa and Botswana were in the <25% bracket. This implies that the funding from international sources was over 50% of the combined international and domestic public funding for the HIV and AIDS response. Domestic public investment in HIV and AIDS in East Africa is still very low. This means that even if the Partner States increase their domestic expenditures on HIV and AIDS, there will be requirement for international support as it is most unlikely that domestic spending will surpass contributions from development partners in the short and medium term.

11.2.2 External Financing of the Epidemic

Bilateral support: Donor support for Rwanda and Uganda in 2009/10 combined was $465 million (9, 12). Against this, a closer look at bilateral aid also reveals that it was over three times the combined resources contributed by multilateral donors and other international funders. In particular, bilateral aid accounted for 76% of all international support while multilateral aid provided 22% leaving only 2% of the resources to be attributed to the other development partners.

The United States Government (USG) through PEPFAR is the largest bilateral contributor to support for HIV and AIDS response in the EAC. With the year 2009/10, USG contributed a total of $335 million to support the national response to HIV epidemic in Rwanda (12), Uganda (13) and Burundi (14). This was not only 94% of the bilateral aid for HIV and AIDS, but was also (a) 71% of total donor funding and (b) 64% of the overall expenditure for HIV and AIDS response in Rwanda, Uganda and Burundi.

Figure 31: Funding from external donors for HIV and AIDS in Rwanda, Uganda and Burundi, 2009/10



Source: Rwanda (2012, Mukobe & Kavuma (2011) and Burundi (2010).

The other bilateral donors include DfID, Irish Aid, DANIDA, Germany, Japan, Belgium and Switzerland. There is however selection of countries for support by some donors. For instance, Germany provides support for HIV and AIDS in Kenya and Rwanda while DfID did the same only for Uganda and Kenya. On the other hand, DANIDA only supported Uganda while Switzerland and Belgium did the same for Rwanda.

Multi-lateral support: The major multilateral funding agencies for HIV epidemic in the region include GFATM, World Bank, European Commission and UN agencies. GFATM is the dominant multi-lateral agency, contributing more than 80% of the resources from multi-lateral agencies as is shown in the table below using data from Burundi, Rwanda and Uganda.

Table 24: Sources of Multi-lateral Funding for HIV and AIDS in East Africa, 2009/10

SOURCE	Burundi	Uganda	Rwanda	TOTAL	PERCENTAGE
GFATM	4,372,055	24,170,000	67,389,878	95,931,933	80.4
World Bank	8,605,470			8,605,470	7.2
UN Agencies	1,073,452	10,000,000	1,917,394	12,990,846	10.9
European Commission			1,148,033	1,148,033	1.0
Others			675,167	675,167	0.6
TOTAL	14,050,977	34,170,000	71,130,472	119,351,449	100.0

Source: Rwanda (2012) and Mukobe & Kavuma (2011) & Burundi (2010).

The HIV component of the GFATM signed for the EAC countries ranges from 14% for Zanzibar to 66% for Rwanda (16).

Table 25: HIV Portfolio in the GFATM Funding Support to East Africa

COUNTRY	Total Grant Amount Signed ($)	Proportion spent on HIV (%)	CUMMULATIVE HIV DISBURSEMENTS ($m)	
			2011	2012
Burundi	261,843,222	57	69.5	82.7
Kenya	597,608,048	53	118.2	177.1
Rwanda	1,018,168,176	66	341.2	451.8
Uganda	566,309,252	43	117.6	172.7
Tanzania	1,444,195,377	57	393.5	494.1
Zanzibar	25,922,599	14	3.7	3.7

Source: http://portfolio.theglobalfund.org/en/Country/Index/

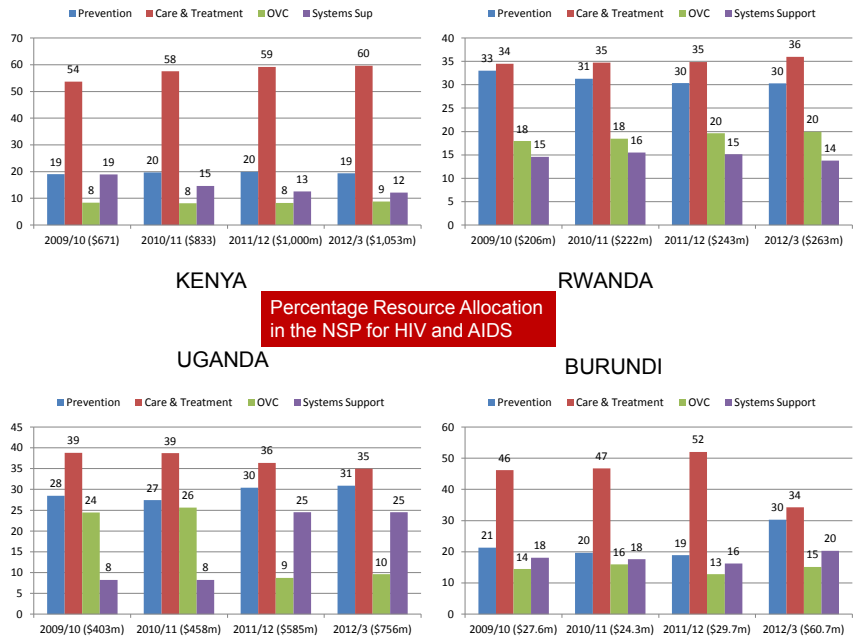
11.3 Allocation and Utilization of Resources

There is variation in the budgetary allocations of resources for the different key sub-components of the strategic plans in the EAC Partner States. Against this however, care and treatment has tended to take the largest share compared to prevention and other areas. In terms of actual resource utilization, care and treatment even took more resources than earlier planned. This is partly attributed to the role played by the major funders of the regional response in allocating their contributions that form the bulk of respective national responses.

11.3.1 Budgetary Allocation of Resources

In the three countries whose resource allocation were analyzed as shown in the figure below, there was a consistent increase in total resources projected for HIV and AIDS between 2009/10 and 20012/13 (1, 2, 3, 4, 5, 6, 7, 8). The resources increased from $671m to $1,053m for Kenya, and from $206m to $263m for Rwanda while for Uganda it increased from $403m to $756m in the same period of time.

Figure 32: Percentage Resource Allocation in NSP for HIV and AIDS in EAC Partner States



Source: CNLS Burundi (2012), NACC (2009), UAC (2007), CNLS Rwanda (2009).

In Kenya, nearly 60% of the resources were allocated for care and treatment in each year while about 35% was similarly allocated in Rwanda and Uganda. Regarding prevention, in Kenya, a fifth of the resources in each year was allocated to efforts related to addressing transmission of HIV infection. However, while in Rwanda there was a modest decrease from 33% in 2009/10 to 30% in 2012/13, in Uganda it was the reverse with resource allocation increasing from 28% to 31% in the same period for prevention.

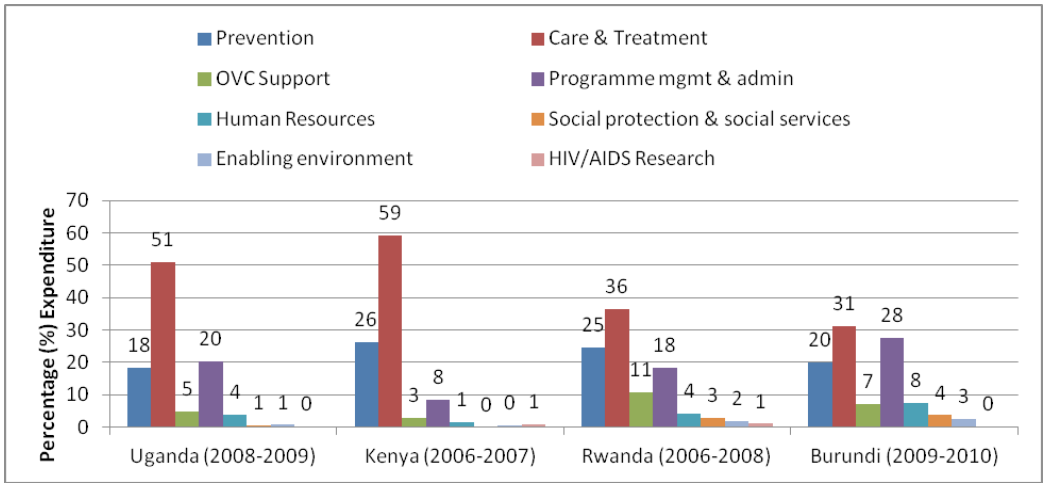
11.3.2 Utilization of Resources

It is important that investment in HIV and AIDS activities should be smart enough to produce the necessary and intended results. In this regard, this section presents the findings on resource allocation in NSP and actual expenditure from the NASA study.

The National AIDS Spending Assessment focuses on nine categories of expenditure areas, namely, Prevention, care and treatment; OVC support; Programme management and support; Human resource' Social protection and social

services; Enabling environment and HIV and AIDS research. Information on NASA conducted in the region was found for Uganda 2008/09 and 2009/10 (9), for Kenya 2006/07 and 2007/08 (10), Rwanda for 2006 to 2009 (17) and Burundi for 2009 and 2010 (14). In Uganda a total of $1,166 million ($586.6 million in 2006/7 and $579.7million in 2009/10) was spent in the period while in Kenya it was $669.6 million ($307.7 in 2006/07 and $361.9 million in 2007/08); in Rwanda the spending was $87.6 million in 2006 and $74.6 million and $110.8 million in 2007 and 2008 respectively. In Burundi, the total expenditures were $27.0 m and $41.8m respectively in 2009 and 2010 (14).

Figure 33: Breakdown of AIDS Spending by Category for Uganda, Kenya, Rwanda and Burundi, 2006-2010



Source: NASA Uganda (20009), Kenya (20007), Rwanda (2008), Burundi (2009-2010)

It is clear that in the four countries, over half of the resources were spent on care and treatment in Uganda and Kenya while in Rwanda and Burundi fewer than 40% of the resources were used for this purpose. The next category of high expenditure was on prevention followed by Programme Management and Administration. In Rwanda and Kenya, a quarter of the funds were used for prevention while in Uganda and Burundi about one fifth was used in activities related to the prevention of new infections. However, expenditure for programme management was highest in Burundi where 28% of the AIDS spend was in this category compared to only 8% in Kenya.

In the case of Uganda, the NASA study was carried out during the period when NSP 2007/8-2011/12 was being implemented. At that time, resource allocation was 28% for prevention, 39% for care and treatment, 25% for OVC and only 8% for systems strengthening. Thus, it is clear that care and treatment overshot its allocation in the period by 12% resulting in an under spending on prevention by about 10%. Again although only 8% of the resources were allocated to systems strengthening that includes programme management, expenditure in this area was more than double its projected allocation.

11.4 Addressing Resource Gaps in Sustainable and Predictable Manner

There is need to increase the fiscal space for HIV investment in order to meet the ever increasing resource gap in the national and regional response. It was noted that with the new WHO Guidelines of 2013 for access to ART, this gap is going to increase to an exceedingly high level ever witnessed before. Two things will have to be done, namely, to rationalize the use of existing resources so that we can achieve more with what we have and also to explore new options for domestic resource mobilization and also ensure that the development partners not only make good of their existing commitments but also recommit themselves for longer-term and predictable investments on HIV and AIDS in the region.

11.4.1 Using existing resources more efficiently

One of the key areas to be addressed using existing resources is for the individual country to improve on resource allocation and utilization in effective interventions. It was noted that a substantial proportion of resources are expended in programme management and less on prevention. An appropriate balance needs to be made in resource allocation across the different components of the national response. These are the Spectrum and Goals Models that could be used upfront to assess the outcomes of various combinations of effective evidence-based interventions before resources are used. These models need to be used at the planning stage and dynamically during the implementation so that adjustments can be made on an annual basis.

In some countries, like Uganda, ARVs are being produced. It will be necessary to explore how the cost of the drugs from these local factories can be reduced further so that more of the eligible PLHIV can be given treatment. Although this will also ensure sustainability at both national and regional levels, it will require (a) persuasion of Partner States to make their procurement from such factories so that the region benefits from economies of scale (b) the producers to improve on the qualities of the drugs.

The health systems in most of the Partner States are weak in terms of requisite human resource, laboratory capability at various levels etc. This calls for strengthening of such systems and also for integration of HIV services with other services provided by the health and non-health institutions. The period when HIV and AIDS was an emergency has long passed, hence, more strategic planning for rationalizing the epidemic in existing health and other institutions will go a long way in sustaining the response. Some countries have tried approaches such as task shifting. This needs to be scaled up.

It is important for political, technical, cultural and religious leaders in the region to note that every dollar spent on AIDS is an investment with enormous impact on the people and the economy of the country. Besides, the returns from the investment multiply over time. This therefore requires more commitment and decisions for more efficient domestic budgeting and spending. In most Partner States, HIV and AIDS is recognized as requiring a multi-sectoral response but when it comes to domestic resource allocation, government allocation and actual public expenditure is minimal, which hampers mainstreaming efforts.

Partner States need to be reminded from time to time about the Abuja Declaration in which African Heads of State committed to allocate 15% of their national budgets to health. This contribution would be very important to the national response because with the implementation of the WHO Guidelines 2013 on ART, the share of responsibility for the health sector will even be greater. Thus, more and more of the funding for health will be used in addressing HIV and AIDS and also improving the health system through which a large percentage of HIV and AIDS services are delivered.

11.4.2 New Financing Options

New Investment Framework: In 2011, UNAIDS developed a people-centred approach for financial investments in the HIV response. The smart and results oriented investment framework strategically focuses on three key building blocks of the national HIV responses that are categorized under basic programme activities, critical enablers and synergies with development sectors. Basic programmatic activities address (a) Treatment, care and support for people living with HIV; (b) Focused interventions for key populations; (c) Behaviour change programmes; (d) Condom promotion and distribution; (e) Medical Male Circumcision; and (f) Prevention of Mother to Child Transmission. The critical enablers are activities that are necessary to support the effectiveness and efficiency; they include social enablers and programme enablers. The development synergies are investments in other sectors that can have a positive effect on HIV outcomes; these include social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems (including treatment for sexually transmitted infections and blood safety), community systems and employment practices. The Partner States need to apply the investment approach in planning for the national response. When (a) the current returns to investment (b) projected returns from new investment (c)

justification for more funding including proposed improvement in efficiency of resource usage (d) projected financing from traditional and non-tradition sources are clearly documented, then it will be easier to convince the policy makers to accept the HIV investment case and participate more effectively in resource mobilization for its implementation. This is different from the current practice in which HIV and AIDS stakeholders budget for HIV and AIDS and submit to Ministry of Finance just like it is done for any other projects in the country.

Partner States also need to diversify domestic and regional funding sources in order to ensure financial sustainability. Innovative funding mechanisms need to be explored. Through taxes and levies, for example, Zimbabwe was able to establish an AIDS Trust Fund that was instrumental in scaling up the national response when external funding support was at a minimum. In this regard, Kenya and Uganda are already in advanced stages for establishing AIDS Trust Funds whose components include additional excise taxes (on some commodities such as alcohol and tobacco), social insurance schemes, corporate social responsibility etc. In Tanzania, an ATF has already been approved by the Cabinet. These efforts need political and technical support at the highest levels in these countries.

Engaging Development Partners: The first step in engaging development partners is for government to ensure that the existing ADPs are retained as funders of HIV and AIDS interventions. In the recent past, development partners have either not disbursed all the resources that they pledged or have withdrawn altogether from supporting HIV and AIDS. One of the factors that has lead to this is the issue of weak governance, corruption, poor resource management and accountability which many times resulted in loss and diversion of resources. Efforts have to be made to demonstrate that government is taking responsibility and adequate measures to ensure that resources are well used in future.

Governments also need to demonstrate to development partners that they are shouldering the national response by sharing the responsibility for financing which also requires additional contributions from development partners and non-state actors including private sector, civil society and local communities. It is in this respect that development partners will need to be asked to recommit themselves to support the national and regional response through longer-term and predictable investments on HIV and AIDS. Since external resources form most of the funding in the region, planning and sustaining the response become very difficult when funds are unpredictable. Thus, the principle of shared responsibility and global solidarity needs to be upheld if the funding gap is to be narrowed and financial sustainability ensured.

To date, the existing international AIDS development partners that are supporting national and regional response to the epidemic do not include the emerging economies of the BRICS countries (i.e. Brazil, Russia, India, China and South Africa). These countries provide opportunities outside traditional sources of external funding. South Africa, for instance, is a major investor in the East African region which is also the destination of many manufactured goods from India and China. Hence, steps need to be taken to bring these countries onboard.

11.5 Summary on HIV and AIDS Financing in the East African Community

Total budgets and actual funding for HIV and AIDS response in the region has continued to increase in the Partner States signifying greater political commitment in the fight against the epidemic. However, a considerable gap remains between the projected costs of the response and the actual resources mobilized.

Domestic investment in HIV and AIDS has increased but remains lower than the contribution from development partners. With a donor dependence of over 50% this situation means that even if the Partner States increase their domestic expenditures on HIV and AIDS, there will be a requirement for international support as it is unlikely that domestic spending will surpass contributions from development partners in the short and medium term.

USG through PEPFAR is the largest bilateral and overall contributor to support for HIV and AIDS response in the region. Other donors are selective in the countries they support. Currently, the BRICS countries are not particularly involved in the response to HIV and AIDS in the region.

In all the countries, care and treatment take about 40% of the NSP resources. However, in utilization, care and treatment takes 50% of the resources followed by prevention; programme management and administration varies from country to country with Uganda spending 20% of its resources on this compared to 8% and 18% for Kenya and Rwanda respectively.

There is a need to increase the fiscal space for HIV investment in order to meet the ever increasing resource gap in the national and regional response. With the 2013 WHO Guidelines for access to ART, this gap is going to increase to an exceedingly high level. To date, none of the Partner States has moved any closer to meeting the Abuja Declaration in which African Heads of State committed to allocate 15% of their national budgets to health. There is also limited information on macro-economic impact and socio-economic impact of HIV and AIDS and TB in the various sectors at national and regional level. This makes objective arguments with empirical evidence on need to invest in these conditions difficult.

In order to close the resource gap in the response to HIV and AIDS in the region, the following actions are recommended:

EAC

- Establish a health fund for supporting key priority regional interventions in the EAC region
- Increase advocacy on HIV financing with the option of establishing a regional fund for HIV, AIDS and TB
- Generate reliable and easily accessible data on financing and expenditure patterns in the region
- Increase advocacy for more efficiency, transparency and accountability in the allocation, utilization and reporting on resources for HIV and AIDS and health among EAC Partner States

Partner States

- Set up sustainable funding mechanisms for the HIV and AIDS response in view of diminishing financial support from traditional development partners
- Promote performance-based financing in the health sector
- Conduct macro and socio-economic impact studies on HIV, AIDS and TB in key sectors
- Progressively work towards increasing respective Partner State domestic budgets for HIV and AIDS interventions and health in general to 15% of the national budgets in line with the Abuja Declaration of 2001
- Create a mechanism to maximize private sector contribution for the national response

Development Partners

- Increase advocacy for more efficiency, transparency and accountability in the allocation, utilization and reporting on resources for HIV and AIDS and health among EAC Partner States
- Encourage more non-traditional funders of health and HIV and AIDS programmes to provide resources for health, HIV, AIDS and TB in the region

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ANNEX I: STATUS OF 2011 UN POLITICAL DECLARATION TARGETS

STATUS AND COMMENTS ON EACH PARTNER STATE11

2011 UN GENERAL ASSEMBLY TARGETS	COUNTRY	STATUS	COMMENTS
1. Reduce sexual transmission of HIV by 50% by 2015	Burundi	On track	• Prevalence of HIV has declined from 2% in 2004 to 1.3% in 2012. • The number of new infections has declined from 5,600 to 4,600 between 2011 and 2012
	Kenya	On track	• New infections have reduced from 92,000 per year to 85,000 per year by the end of 2012. • Advocacy has targeted the parliamentarians, FBOs for social mobilization. • Voluntary MMC programs have been scaled up • Education sector developed a policy on life skills developed for youth in school • Size estimation of MARP conducted in 2012 for helping programs target these groups
	Rwanda	On track	• Increased condom distribution, availability and accessibility • Targeted interventions conducted for key populations (e.g. MSM and female sex workers) • Voluntary male circumcision promoted
	Uganda	Not on track	• Scaling up behavioral interventions through IEC/BCC and interpersonal communications • Expanding and promoting voluntary and confidential HIV testing and counseling • Promotion and roll-out safe male circumcision
	Tanzania	Not on track	• A decline in HIV prevalence from 7% in 2003/4 to 5.7% in 2007/8 to 5.1% in 2011/2012 • A study to examine the extent and context surrounding the practice of heterosexual anal sex has been conducted • Voluntary medical male circumcision is ongoing with coverage reaching 72% already
2. Reduce transmission of HIV among people who inject drugs by 50% by 2013	Burundi	N/A	
	Kenya	On track	• MARP size estimation consensus report 2013 produced • Drafted policy document on Opiates Substitution Therapy and Medical Assisted Therapies • Needle Syringe Programs initiated • National guidelines and SOPs for MAT and NSP developed
	Rwanda	N/A	
	Uganda	N/A	
	Tanzania	Not indicated	• Methadone Substitution therapy with a daily recommended maintenance dose (60 mg methadone) has been implemented at the Muhimbili National Hospital in Dar es Salaam at a small scale (900 PWIDS) with plans to expand to other hospitals, such as in Kinondoni Municipality.In Zanzibar interventions such as sober houses, peer support, overdose management, and behavioral interventions for PWIDS are implemented. • Guidelines for expanding access to prevention and treatment have been developed • Bio-behavioral and size estimation surveys carried out

11 CLNS (2013). Rapport d'activités sur la lutte contre le sida et rapport sur les progrès enregistrés vers un accès universel (Burundi), 2013.
NACC (2013). Global AIDS Response Progress Report: Mid-Term Review Report of the HLM Target. Kenya.
MoH (2013). 2011 Political Declaration on HIV and AIDS: Mid Term Review Report. Rwanda
TACAIDS (2013). Country Progress Report (2011-2013) on The United Nations General Assembly 2011 Political Declaration on HIV and AIDS (July 2013). Tanzania
UAC (2013). United Nations General Assembly 2011 Political Declaration on HIV and AIDS : Mid Term Review Report Uganda

2011 UN GENERAL ASSEMBLY TARGETS	COUNTRY	STATUS	COMMENTS
3 Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths	Burundi	On track	• Reduction of new infection among women 15-49 years has declined from 2,000 to 1,800 between 2009 and 2012 • Percentage of women receiving ARVs (excluding sdnvp) to prevent MTCT has increased from 29 to 54% between 2009 and 2012
	Kenya	On track	• eMTCT roadmap and national strategy developed • High level advocacy meetings with politicians convened.. • Forums with counties on HIV targeting eMTCT advocacy held • County HIV profiles with strategic information on eMTCT developed • New treatment guidelines (includes Option B+) adopted. • Presidential declaration on free maternity care in all public health facilities implemented • Kenya Mentor Mothers Programme integrated in eMTCT
	Rwanda	On track	• National guidelines revised to accommodate option B+ • Capacity of health care providers strengthened to enable scale up of PMTCT services and roll out of revised guidelines • National eMTCT strategy developed based on bottleneck analysis
	Uganda	On Track	• Government launched and is currently implementing the National Accelerated Plan for elimination of Mother to Child Transmission of HIV (2012 – 2015) • Increasing access to antenatal care, information, counseling and other HIV services among pregnant women • Increasing the availability of and access to effective treatment for women living with HIV and access to effective diagnosis (EID) and treatment for infants born to HIV positive women
	Tanzania	On track	• Country has adopted a virtual elimination of MTCT strategy with four prongs • PMTCT services integration in the routine RCH services has been implemented with a remarkable 93% integration • Decrease in MTCT from 26,000 children in 2009 to 15,000 in 2012, a 48% reduction • 77% of HIV infected pregnant women are receiving ART as part of the PMTCT

2011 UN GENERAL ASSEMBLY TARGETS	COUNTRY	STATUS	COMMENTS
4 Increasing universal access to HIV treatment by PLHIV	Burundi	On track	• There is 67% coverage of ART among those that are eligible according to 2010 WHO Guidelines
	Kenya	On track	• 2009 WHO ART treatment guidelines including improved commodity forecasting and quantification revised • Sustained treatment scale up resulting in the number of PLHIV on ART to increase from 468,717 in 2010 to 604,000 in 2012 and pediatric ART coverage at 38% in 2012 • The number of health facilities providing ART increased significantly from 1,405 in 2011 to 1,829 in 2012
	Rwanda	On track	• Increased geographic coverage of facilities offering comprehensive HIV services • Decentralization and integration of services • Guidelines updated based on evidence and WHO recommendations
	Uganda	On track	• Revised the 2011 National ART Policy to allow non-medical officer i.e. Nurses, Midwives and Clinical Officers to initiate and maintain patients on ART • Increasing access to ART through rapid accreditation of both public and private health facilities accompanied by capacity building for ART service provision • Increased proportion of HIV Budget allocated to treatment over the past years and rationalized procurement and distribution of drugs "One Supplier – One Site Policy"
	Tanzania	Not indicated	• 2010 WHO guidelines for ARV initiation adopted • The number of people receiving ARV has increased, reaching 432,700 PLHIV • ART supply chain has been assessed in order to identify bottlenecks and inform improvement plans.
5. Reduce TB deaths in PLWHIV by 50% BY 2015	Burundi	On track	• TB patients testing positive for HIV has declined from 23% to 22% between 2010 and 2012 • HIV positive TB patients started on ART increased from 40% to 48% between 2010 and 2012.
	Kenya	On track	• Developed and increased roll-out of 5I's operational materials. • Adopted WHO 2010 recommendations that all HIV/TB co-infections to initiate ART.
	Rwanda	On track	• Active case finding and treatment of TB cases through DOTS (community-based case finding & improved lab detection) • Systematic provision of ARVs to co-infected people • Infection control measures promoted
	Uganda	Not on track	• The National TB and Leprosy Program (NTLP) has revised its 3-year strategic plan 2012/13-2014/15 to include the three 'I"s - Infection Control (IC), Intensified Case Finding (ICF) and Isoniazid Preventive Therapy (IPT) • TB/HIV collaboration has been strengthened • Enhancing community involvement through Implementation of DOTS
	Tanzania	Not on track	• Guidelines and protocols developed by WHO or CDC are in operation in the country • The numbers of people screened for, and started on IPT for TB have increased with 25.9% of all people co-infected with HIV and TB receiving treatment for both HIV and TB.

2011 UN GENERAL ASSEMBLY TARGETS	COUNTRY	STATUS	COMMENTS
6. Close the national AIDS resource gap by 2015 and reach annual global investment of US$22-24billion in low-middle income countries	Burundi	No data	
	Kenya	On track	• Cabinet memo on sustainable financing; proposed that 1% of government revenue should support HIV and AIDS programmes. • Advocacy and Resource mobilization carried out • Sessional Paper on sustainable financing needs to be fully implemented
	Rwanda	Not on track	• Extension requested of Global Fund support to the NSP • Negotiations ongoing with USG to fund NSP • Efficiency gains being sought to minimize costs (e.g. ARV costs, aligning donor-funded programs to the NSP
	Uganda	Not on track	• Resources mobilized through different mechanisms namely PEPFAR, CSF, GF, GoU • Working paper developed for internal resource mobilization • Review and restructuring of CSF-management and GF-CCM carried out
	Tanzania	Not on track	• A health financing strategy proposing a national insurance scheme, fiscal contributions and taxation models, and public private partnerships for health financing has been developed • Tanzania AIDS Trust Fund is under discussion • HIV service-delivery model options being reviewed to increase efficiency in resource spending
7. Eliminate gender inequalities and gender-based abuse and violence and increase capacity of women and girls to protect themselves from HIV; reduce the burden of care on women and girls	Burundi	On tack	
	Kenya	On track	• National Gender and Equality Commission established to oversee and ensure women empowerment and reduction in gender inequalities • Directorate of Gender in the Ministry of Planning & Devolution established • Sexual Offences Act, 2006 operationalized • National Gender Based Violence Framework developed • Female Genital Mutilation/Cut was prohibited • Women representation in policy making levels increased through affirmative action • Advocacy by leading stakeholders scaled up
	Rwanda	On track	• Capacity building of government and CSOs to promote gender equality in the HIV response • National GBV Policy and Strategic Plan adopted • IEC materials targeting young women 15-24 developed
	Uganda	Not on track	• Capacity of cultural and community leaders was built to enable them mobilize the communities for change of harmful socio-cultural norms and gender practices • Local governments empowered and supported key implementers at decentralized level in mainstreaming gender in their HIV/AIDS and social support programmes • Legal and social support services for the protection of women and young people against sexual and gender SGBV on account of HIV were provided
	Tanzania	Not indicated	• Gender policy and laws and regulations against violence in place • Sensitization and training of law enforcement officers and the judiciary on the prevention of gender based violence have been conducted • Children and GBV desks have been established in all district police stations

2011 UN GENERAL ASSEMBLY TARGETS	COUNTRY	STATUS	COMMENTS
8. Eliminate stigma and discrimination against people living with or affected by HIV through promotion of laws and policies based on HR	Burundi	On track	• Over 70% of men and women have positive attitude to people living with HIV
	Kenya	On track	• HIV and AIDS Equity Tribunal established and operational
	Rwanda	Not on track	• Community-based campaigns to reduce HIV-related stigma and discrimination • Second PLHIV Stigma Index survey being conducted • PLHIV supported to access income generating activities
	Uganda	On track	• Mobilization of political, religious and cultural leaders conducted for enhancing campaigns and public dialogues on HIV-related stigma and discrimination in the community • Training carried out and consequently, SGBV and HIV-related stigma and discrimination cases are being given legal and protection services • PLHIV are actively facilitated to participate (e.g. as expert clients) in the national response to HIV/AIDS epidemic
	Tanzania	Not on track	• Small scale programmes to reduce stigma and discrimination have been implemented, mostly by partners and the networks of communities living with HIV
	Zanzibar		
9. Eliminate HIV-related restrictions on entry, stay and residence	Burundi	N/A	
	Kenya	N/A	
	Rwanda	N/A	
	Uganda	N/A	
	Tanzania	N/A	
10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts.	Burundi	On track	• There is integration of TB/HIV/MCH services
	Kenya	On track	• Development of RH TB/HIV/MCH tools and strategies and rapid results initiatives conducted, MCH, TB, HIV. • Cervical cancer screening for all HIV positive women, integrated in the Comprehensive Care Centers • Strengthened M&E HIV monitoring through DHIS
	Rwanda	On track	• RBC created to integrate health programs under one institution • Integrated HIV service delivery promoted (e.g. immunization & HIV testing, SRH and family planning) • Joint supervision visits conducted
	Uganda	Not on track	• Building capacity for delivery of integrated HIV/AIDS-related services through multi-skilling, multi-tasking, coaching, mentoring and joint planning • Expanding and strengthening linkages and referral systems between different service provision platforms for HIV/AIDS, TB, NCDs interventions • Supporting service providers including central and local governments and CSOs to integrate HIV/AIDS into their sector programs (e.g. human rights, food and nutrition, water and sanitation etc)
	Tanzania	Not indicated	• 93% of RCH clinics are now providing PMTCT services • Linkages between non- communicable diseases and HIV AIDS (e.g. integrating cervical cancer screening and treatment with HIV services) is ongoing on project basis

(Footnotes)
1 BSS (2011) Behavioral Surveillance Survey. Burundi.

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